Indiana's Children's Health Insurance Program Annual Evaluation Report

April 1, 2003

EP&P
Consulting, Inc.

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EXECUTIVE SUMMARY

Indiana's Children's Health Insurance Program (CHIP) offers the State a funding mechanism for receiving federal subsidies to provide health insurance to children who are not eligible for Medicaid. As of October 2002, 66,900 children were enrolled in Indiana CHIP.

Indiana implemented its CHIP program in two phases:

- Phase I, which began July 1, 1998, expanded Medicaid to children below the age of 19 with family incomes of no more than 150% of the Federal Poverty Level (FPL). This phase is a Medicaid expansion and does not require members to pay monthly premiums.

- Phase II, which began January 1, 2000, is a non-Medicaid premium-share program designed to provide coverage to children with family incomes above 150% up to 200% of the FPL.

In March 2000 EP&P Consulting, Inc. conducted its first evaluation of Indiana's CHIP. Since that time annual evaluation reports have been conducted for calendar years (CY) 2000 and 2001. This third report highlights trends in enrollment and services used by children in CHIP during CY 2002. As was the case in previous years, this annual evaluation report includes both original analyses of eligibility and claims data as well as analyses of existing Hoosier Healthwise monitoring reports. Service utilization trends of children in Indiana's Medicaid program as well as available national CHIP and Medicaid data have been used as comparison benchmarks.

The questions at the outset of this year's CHIP evaluation process included:

- What will be the enrollment rate of children eligible for CHIP?

- How will the service utilization of children in CHIP compare with that of children in the Medicaid program (both in terms of the amount of services being utilized and the types of services)?

- Will service utilization vary between children enrolled under Phase I of CHIP (the Medicaid expansion) versus Phase II of CHIP (the premium share program)?

The findings of the annual evaluation report for the CHIP program for CY 2002 are very similar to the findings of the previous year. There were no systemic issues that affected enrollment into the CHIP or CHIP children's access to services. Available data also showed that the families of CHIP children gave the program higher marks for overall satisfaction than Medicaid members and higher than national studies for similar populations. In addition, overall utilization and cost data are similar for CHIP and Medicaid children across the majority of services, with few major

differences. The one service area that CHIP children have continually utilized more than Medicaid children in the past three years is dental services.

The annual evaluation found that even though service utilization trends are similar between CHIP and Medicaid, the per member per month (PMPM) expenditure was less than Medicaid in both CHIP Phase I and CHIP Phase II with respect to primary care physician services, non-primary physician services, inpatient hospital and outpatient hospital services. For pharmacy scripts, utilization was similar and PMPM expenditures were also similar between CHIP and Medicaid children. The only area where CHIP was more expensive than Medicaid on a PMPM expenditure basis was for dental services. The utilization trends between CHIP Phase I and Phase II are similar overall, and the expenditures incurred on a PMPM basis are slightly lower for Phase II members than Phase I members.

Enrollment in CHIP continues to grow. The number of children receiving health care through CHIP was at its highest point ever at the end of 2002 (66,900 members in October 2002). The net increase of members from 2001 to 2002 was higher than it was from 2000 to 2001. Additionally, more members receive services from the Risk-Based Managed Care delivery system (RBMC) of CHIP. For CHIP Phase I, the percentage enrolled in RBMC grew from 18% to 39% from 2001 to 2002; for CHIP Phase II, the percentage grew from 14% to 37%. The RBMC system, along with the Primary Care Case Management (PCCM) delivery system, ensures that children have a single source for the coordination of their care. In 2002, nine out of 10 children in CHIP were enrolled in this service model.

As Indiana CHIP continues to move from an "implementation phase" to a "maintenance/ongoing operational phase", the findings of this evaluation support the following recommendations:

- Since the average period of enrollment for both CHIP Phase I and Phase II members decreased from 2001 to 2002, the CHIP Office should track the reasons for disenrollment more closely. This is especially true given the fact that the average period of enrollment for children in CHIP is about two-thirds that of children in Medicaid.

- Another area to focus on is the use of physicians that are not registered with the State as primary medical providers (PMPs). This evaluation found that utilization for CHIP members was similar for both services received from PMPs and those that are not PMPs. This implies that children are just as likely to see someone that is not responsible for coordinating their care as someone who does. However, further analysis should be conducted to determine if children are merely seeing these "non-PMP" providers because they are within another PMP's group practice, the non-PMP providers are specialists that children have been referred to by their PMP, or because the children live in areas where there are not PMPs available.

- Related to the issue above, the CHIP Office is encouraged to work with the OMPP to gain a better understanding if PMP panel capacity is an issue. Panel capacity refers to the number of patients a PMP agrees to accept. This is tabulated for all PMPs within a county and measured on a county-by-county basis. As of January 2003, there were seven counties that had 100% or higher (full) capacity of all of the slots available from pediatric doctors to accept new members. Although not entirely conclusive, this analysis may indicate that there are areas in the state where enrollment increases are outpacing available physician capacity. These counties should be further reviewed to determine which physicians are still available to accept new members. Additionally, it is suggested that the panel capacity figures for each county should be measured against commercial plans. Some states have found that, although panel capacity may be an issue, the Medicaid agency in the state has more slots available than commercial plans in the same area.

SECTION I
OVERVIEW OF FINDINGS

INTRODUCTION

The State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act. Title XXI offers states a funding mechanism for receiving federal subsidies to provide health insurance to children who are not eligible for Medicaid. In implementing SCHIP, states have the option of providing benefits through an expanded Medicaid program, by establishing a separate non-Medicaid program, or through a combination of these two program designs.

Indiana's CHIP was designed as a "combination" program and was implemented in two phases:

- Phase I, which began July 1, 1998, expanded Medicaid to children below the age of 19 with family incomes of no more than 150% of the Federal Poverty Level (FPL).

- Phase II, which began January 1, 2000, is a non-Medicaid premium-share program intended to provide coverage to children with family incomes above 150% of the FPL up to 200% of the FPL.

Indiana's Office of Medicaid Policy and Planning (OMPP) manages the CHIP program. Eligibility determination is conducted by the Division of Family and Children (DFC). Together, these divisions are responsible for the operation of the Hoosier Healthwise benefits programs, including CHIP. The model for delivering services to CHIP members is the same as it is for children in the rest of Hoosier Healthwise.

FINDINGS

This is the third annual evaluation of Indiana's CHIP conducted by EP&P Consulting, Inc. (EP&P). This year's evaluation focuses on trends in enrollment, service utilization, payments, access to services/providers, and quality monitoring. The evaluation includes analyses of service claims for the period January 2000 to December 2002 to:

- Determine if children enrolled in Phase II, the premium-share program, access and utilize services in the same manner as children enrolled in Phase I, the Medicaid expansion program and if there have been any changes since prior evaluations.

- Determine if children enrolled in CHIP are utilizing services in a manner similar to Medicaid children and if there have been changes since prior evaluations.

- Determine if there are differences in utilization patterns among the three types of service delivery models within Hoosier Healthwise—the Primary Care Case Management (or PCCM) system, the Risk Based Managed Care (or RBMC) system, and the Fee-For-Service (or FFS) system.

- Determine if differences in per member per month (PMPM) expenditures between CHIP Phase I, CHIP Phase II and children in Medicaid is a result of differing utilization patterns or the cost of services.

- Determine if there are differences in utilization and expenditure patterns between age groups to better understand the underlying differences between CHIP and Medicaid. Past evaluations found that the composition of the ages within a program (e.g. more teenagers in CHIP Phase I, more infants in Medicaid) often drove differences in both utilization and payment.

- Determine if there are any systematic access or quality issues that have changed between calendar year 2001 and 2002 that would change findings from the annual evaluation report submitted on April 1, 2002.

Available national and state-level data was obtained as comparative benchmarks with which to measure Indiana's CHIP program. The evaluation also included analyses of internal reporting documents provided by the OMPP that focused on monitoring.

This section of the evaluation provides a summary of findings related to the above issues while the remaining sections of the report provide more detailed analyses results.

What is the enrollment trend for the CHIP program? How does it compare to prior years?

As of October 2002 there were 66,900 children enrolled in CHIP—54,000 CHIP Phase I children and 12,900 CHIP Phase II children. The combined enrollment of the two phases grew 6% from 2001. Growth from 2000 to 2001 was also 6%. However, the first enrollees into CHIP—often referred to as the "Waxman teens"—have been leaving the program over the past few years because they have turned age 19. Therefore, enrollment growth of 6% annually means that the number of newer enrollees have outpaced the number of Waxman teens departing. When the Waxman teens are excluded from enrollment growth trends, the rate of growth in 2002 kept pace with the 2001 rate at 14% for CHIP Phase I and 35% for CHIP Phase II.

What is the rate of disenrollment for the CHIP program?

The average number of months that children are in enrolled in CHIP decreased from 2001 to 2002. For all CHIP children, the average number of months of enrollment fell from 6.8 months in 2001 to 6.3 months in 2002. This is lower than the average months of enrollment for children

in the Medicaid program, which was 9.4 months in 2001 and 9.3 months in 2002. For a recent 12-month period, over 40% of children who enrolled as members were no longer enrolled one year after their start date. This excluded those children who were no longer eligible because they turned age 19. Disenrollment trends may continue to increase since the provision for continuous eligibility for children over a 12-month period was removed on July 1, 2002.

How do children enrolled in CHIP Phase I use services relative to those in CHIP Phase II?

Service utilization was measured in two ways: the percentage of children accessing services and the number of claims per 1,000 eligible and enrolled children. For the major categories of service studied (hospital, physician, dental, and pharmacy services), the percent of children in CHIP Phase I (non-premium share) that used each of these services was similar to the percent of children in CHIP Phase II (premium share) that used these services. This held true in both calendar years 2001 and 2002.

Service utilization was also measured on a "claims per 1,000 eligibles" basis since the size of the two CHIP phases are quite different. Measuring against this factor, CHIP Phase I and II share similar utilization patterns for inpatient hospital, outpatient hospital, and pharmacy services. CHIP Phase II has higher utilization, however, for physician services and dental services.

How does CHIP (Phases I and II) utilization and expenditures compare to Medicaid expenditures for children under the same services?

Service utilization patterns differed between Medicaid and CHIP depending upon the service reviewed. CHIP children had higher utilization for dental services, whereas Medicaid children had higher utilization for hospital and physician services. Pharmacy utilization was similar between the two programs. It should be noted that these findings were also reported last year and that the relative differences between the two programs for each service have remained similar from 2001 to 2002.

A review of service expenditures for the PCCM and FFS delivery systems across inpatient, outpatient, physician, pharmacy and dental services shows that the service with the largest percent of expenditures varied for each program. For CHIP Phase I, pharmacy accounted for the greatest portion of expenditures; for CHIP Phase II, dental services were greatest; for Medicaid, inpatient hospital services were greatest. These were the same findings in last year's report.

How do the per member per month (PMPM) expenditures compare between CHIP Phase I, CHIP Phase II and Medicaid?

The PMPM expenditures for CHIP members in PCCM and FFS increased 0.9% from 2001 to 2002 whereas the corresponding PMPM expenditures for Medicaid children increased 6.7% during this time period. The actual PMPM expenditures for CHIP members ($89 in 2002)

continues to be lower than Medicaid children ($110 in 2002) on core services (hospital, physician, dental, pharmacy). Furthermore, the PMPM expenditures for CHIP Phase II children ($85 in 2002) are lower than for CHIP Phase I children ($89 in 2002).

Are there differences in CHIP service utilization by type of delivery system (PCCM versus RBMC versus Fee-For-Service)?

A larger percentage of CHIP children were enrolled in the managed care portion of the program (PCCM and RBMC) in 2002 than in 2001. For CHIP Phase I, enrollment in managed care increased from 83% to 91% of all members from 2001 to 2002; for CHIP Phase II, the managed care enrollment increased from 70% to 82%. This reflects the fact that in 2002, State legislation required implementation of mandatory enrollment in Hoosier Healthwise managed care in five counties (including Marion County). The remaining children are enrolled in the FFS portion of the program. Most of these children are in FFS for a short period while selecting a doctor in the PCCM or RBMC delivery systems.

While variations in service utilization are seen across types of service delivery systems, there is no consistent trend that would indicate that services are being accessed or provided in a manner distinct to one type of delivery system versus another. For example, inpatient hospital utilization is higher for members in the FFS system while outpatient hospital utilization is higher in the PCCM system. Utilization of primary medical provider (PMP) services is relatively equal between the PCCM and RBMC systems, while services from other physicians (non-PMPs) is higher in the FFS system. Pharmacy utilization is twice as high in the PCCM program than the other two delivery systems, while dental service utilization in the PCCM/RBMC systems is twice as high as that in the FFS system. Differences in utilization patterns may reflect the timing of when services are needed. For example, the higher inpatient utilization within the FFS system may reflect the higher proportion of new members in need of health care services when they initially enter the system and are still enrolled in FFS.

Are there service utilization differences by age?

Many of the children eligible for CHIP Phase I were children who had been too old to qualify for earlier federal expansions in Medicaid eligibility which extended Medicaid coverage to children at higher income levels based on date of birth. Therefore, the age distribution of the children in CHIP Phase I has historically included a higher percentage of teenagers relative to CHIP Phase II and Medicaid. On September 30, 2002, the last of the initial group of Phase I teenagers turned age 19 and became too old to continue to participate in CHIP. Since this group is no longer in Phase I, the composition of members in CHIP Phase I will more closely resemble those in CHIP Phase II and Medicaid. Therefore, the variation between service utilization across the programs due to age differences should be eliminated when differences in members' ages are controlled.

When differences in members' ages were controlled within the evaluation, there were similarities in average payments per claim between CHIP Phase I, CHIP Phase II, and Medicaid. For all three programs, children 13 years of age and older had higher average payments for physician, pharmacy and dental claims. For inpatient services, all three programs had higher average payments for children ages 6-12. No difference in the average payments per claim across age groups was found for outpatient services.

AREAS FOR FURTHER RESEARCH

This evaluation of Indiana's CHIP program has identified areas that the CHIP Office may wish to explore to gain a better understanding of trends occurring in the program:

- ***Further evaluate disenrollment trends.*** Since the average period of enrollment for both CHIP Phase I and Phase II members decreased from 2001 to 2002, the CHIP Office should track the reasons for disenrollment more closely. This is especially true given the fact that the average period of enrollment for children in CHIP is about two-thirds that of children in Medicaid. Also, since the State has removed the policy of continuous eligibility for children, whereby children were previously automatically enrolled for a period of twelve months, there may be further increases in disenrollment in the future.

- ***Evaluate the use of physicians that are not primary medical providers (PMPs).*** This issue is both an access and care management issue. As more and more children enroll in the managed care portion of the Hoosier Healthwise delivery system, the opportunities for better care management increases. However, the data showed that utilization on a claims per 1,000 eligibles basis for CHIP members was similar for both services received from PMP and those providers that are not PMPs. This implies that children are just as likely to see someone that is not responsible for coordinating their care as someone who does. Areas that should be reviewed to gain a better understanding of this issue include:

  - Identify if children are seeking services from non-PMPs that are actually affiliated with a registered PMP in a group practice.
  - Identify if children with non-PMP visits are accessing other specialist physicians due to the type of care they need.
  - Identify if children are seeking services from non-PMPs because there are not enough PMPs in their area.
  - Identify if there is a data reporting issue affecting which providers are labeled a PMP that may be skewing these results.

- ***Continue to monitor and evaluate panel capacity.*** The panel capacity map shown in Section IV indicates that as of January 2003 there are seven counties that have 100%

or higher (full) capacity of all of the slots available from pediatricians to accept new members. This is one more county than found last year. In addition, there are 18 counties that have panel capacity filled above 80% as of January 2003. Although not entirely conclusive, this analysis may indicate that there are areas in the state where enrollment increases are outpacing available physician capacity. These counties should be further reviewed to determine which physicians are still available to accept new members. Additionally, it is suggested that the CHIP Office and the OMPP compare the panel capacity figures for each county against commercial plans. Although panel capacity may be an issue, it may be the case that the Hoosier Healthwise panel capacity is similar to that of commercial plans and that panel capacity issues are linked to broader provider supply issues.

CONCLUSION

Indiana's CHIP has and continues to achieve success in a number of areas. Some of these include:

- ***Enrollment continues to increase.*** Enrollment in CHIP was at its highest point ever at the end of 2002. The net increase of members from 2001 to 2002 was higher than it was from 2000 to 2001.

- ***Service utilization per member is steady for most services.*** Utilization of inpatient hospital, outpatient hospital, primary medical physicians, other physicians, and pharmacy scripts followed the same trends in 2002 as in 2001 when measured on a "claims per 1,000 eligibles" factor. Therefore, it can be inferred from an access standpoint that the level of service delivery is not being impacted by enrollment increases (except for potentially a few counties that may need additional primary medical providers).

- ***Dental utilization continues to increase.*** Dental utilization increased for children in both CHIP and Medicaid in 2002. CHIP members have always utilized dental services at a higher rate than their counterparts in Medicaid, and this trend continued in 2002 as utilization levels reached their highest level since the inception of the CHIP program.

- ***There is not adverse selection between CHIP Phase I and CHIP Phase II.*** The utilization trends between CHIP Phase I and Phase II are similar to one another overall as well as similar to Medicaid, and the expenditures incurred on a per member per month basis are slightly lower for Phase II members than Phase I members.

- ***More CHIP members joined the managed care delivery system in 2002.*** Although there will always be some children in the FFS portion of the program for a short term before they select a PMP, the percentage of children in FFS dropped significantly

from 2001 to 2002 in CHIP. For CHIP Phase I, the percentage in FFS dropped from 17% to 9%; for CHIP Phase II, the percentage in FFS dropped from 31% to 18%. It appears that, through the implementation of mandatory managed care in five counties in 2002, most of these children as well as most new enrollees signed up in the RBMC delivery system. For CHIP Phase I, the percentage enrolled in RBMC grew from 18% to 39% from 2001 to 2002; for CHIP Phase II, the percentage grew from 14% to 37%.

- ***Overall satisfaction with the program remains high.*** Families of children enrolled in CHIP who were surveyed in the most recent annual member survey administered by the OMPP gave more favorable ratings to many questions than Medicaid members of Hoosier Healthwise as well as respondents from national surveys. Ninety percent of CHIP Phase I members and 84% of CHIP Phase II members gave a rating of "very good" or "good" for the Hoosier Healthwise program as compared to the national average of 83% for similar surveys of children in Medicaid programs. Ratings for Hoosier Healthwise primary doctors and specialists were similar between CHIP and Medicaid members (92% and 93%, respectively), and both of these ratings were 10 percentage points higher than the national averages.

SECTION II
OVERVIEW OF INDIANA'S CHILDREN'S HEALTH INSURANCE PROGRAM

This evaluation of Indiana's Children's Health Insurance Program (CHIP) will address enrollment, service access, service utilization, cost trends and quality monitoring. Before findings in these areas are presented, this section provides general background information about the programmatic design underlying Indiana's CHIP. This information will assist in understanding the findings presented in later sections of this report.

What is the State Children's Health Insurance Program (SCHIP)?

The State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act. Under SCHIP, states could develop programs offering health coverage to children up to age 19 in families who are not eligible for Medicaid. In implementing SCHIP, states had the option of providing benefits by expanding their existing Medicaid program, by establishing a separate non-Medicaid program, or through a combination of these two program designs. Indiana has a "combination" program. Children are determined eligible based upon a family's income level. These income limitations vary across the states based on each state's SCHIP design. Indiana's income level for eligibility purposes is capped at 200% of the federal poverty level (FPL), or $36,200 in 2002 for a family of four. This is the level most widely used by state CHIP programs nationwide.

Similar to Medicaid, Title XXI is a joint federal-state funded program with states receiving federal-matching dollars. Title XXI offers states a federal allotment for their SCHIP programs. The amount the federal government pays to each state depends on the state's SCHIP federal matching rate. The SCHIP federal matching rate is a percentage of the total program costs that the federal government will pay. (The term "enhanced" is often used when referring to the SCHIP federal matching rate because the SCHIP matching rate was set at a higher percentage than the Medicaid matching rate as an incentive for states to participate in the Title XXI program.)

The SCHIP federal matching rate differs from state to state because it is based on the state's share of low-income and uninsured children. A state's share of low-income and uninsured children is determined through estimates from the Current Population Survey, conducted by the U.S. Census Bureau. A state cannot receive a matching rate of more than 85% and cannot receive an annual payment of less than $2 million. Indiana's SCHIP federal matching rate was 73.43% in Federal Fiscal Year 2002.

What is Indiana's Children's Health Insurance Program?

Indiana's CHIP was designed and implemented in two phases. Phase I was designed as a Medicaid expansion. Phase I began in October 1997 and extended Medicaid eligibility to children not previously eligible for Medicaid who:

- Were born before October 1, 1983 and
- With family incomes up to 100% of the Federal Poverty Level (FPL); 100% FPL in 2002 was $18,100 for a family of four

The last of these children enrolled in CHIP reached the age of 19 on September 30, 2002. Therefore, this is the last year that this large group of teenagers will be included in the program.

In July 1998, this Phase I Medicaid expansion continued by extending eligibility to a second group of children:

- Children from birth through age 18 and
- With family income up to 150% of FPL who were not previously eligible for Medicaid

Throughout the remainder of this report this first phase of Indiana's implementation of its CHIP will be referred to as the Medicaid Expansion or CHIP Phase I. Enrollment in CHIP Phase I in October 2002 was 54,000 children.

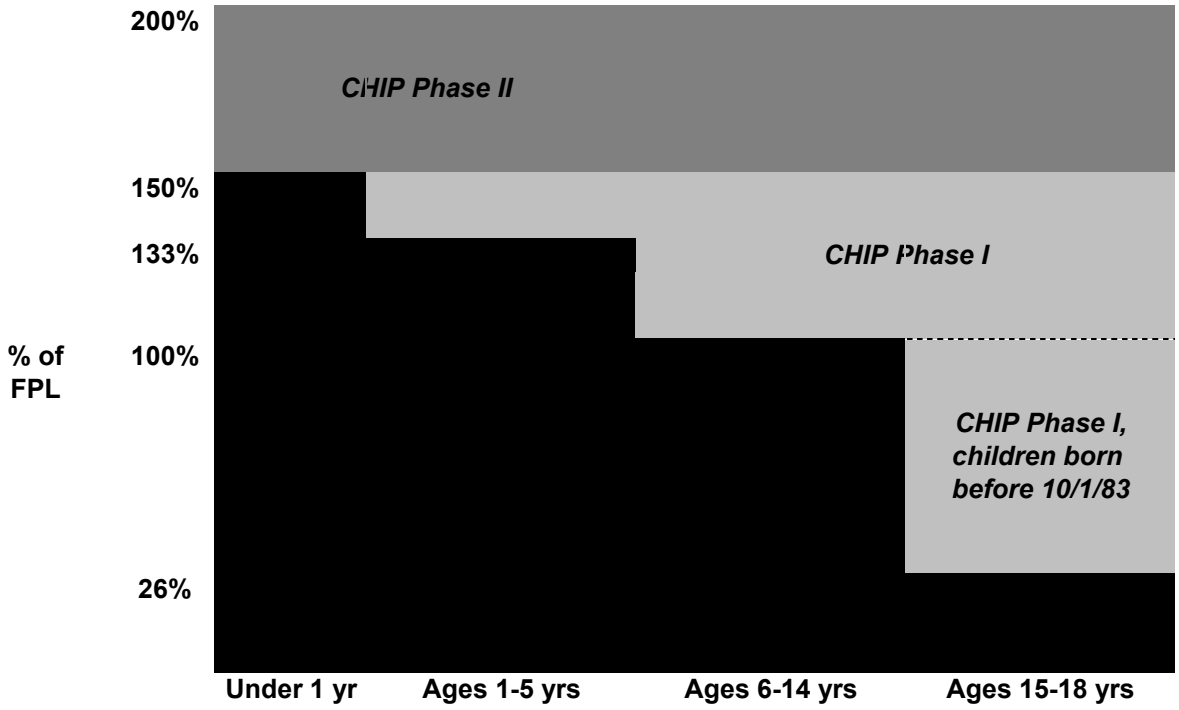
Phase II of Indiana's CHIP was designed as a state-specific, non-Medicaid expansion. Implemented in January 2000, this phase further expanded access to health care coverage by extending eligibility to:

- Children from birth through age 18 and
- With family income above 150% and up to 200% of FPL

Because the second phase is a state-defined program, the State had more flexibility in designing the program. The State used this flexibility to create a package that differs slightly from the Medicaid managed care benefit package and requires members to pay premiums and co-payments. Also, because this phase is not a Medicaid expansion, coverage is not an entitlement. In addition, the benefit package does not include all of the services required under Medicaid. *This second phase of Indiana's CHIP implementation will be referred to throughout the remainder of the report as the Premium Share Program or CHIP Phase II.* As of October 2002, enrollment in the CHIP Phase II was 12,900 children.

Overall program enrollment in both phases of Indiana's CHIP totaled 66,900 children in October 2002.

The diagram below illustrates the "stair-step" eligibility process for children in CHIP.



Hoosier Healthwise uses the Federal Poverty Level (FPL) for income guidelines.
For a family of four in 2002, 150% of FPL was $27,150 and 200% of FPL was $36,200.

How do children in Indiana's CHIP receive health care services?

Children enrolled in both the Medicaid expansion (CHIP Phase I) and the Premium Share Program (CHIP Phase II) portions of Indiana's CHIP receive health care services through the existing Medicaid delivery system, Hoosier Healthwise.

The Hoosier Healthwise delivery system is a multi-faceted delivery system, including two managed care delivery systems existing side-by-side – a primary care case management (PCCM) system and a risk-based managed care (RBMC) system, and a fee-for-service (FFS) system.

- Under the PCCM delivery system, the State contracts with primary medical providers (PMPs), and the PMPs provide or authorize most preventive and primary care services. Certain services, including mental health, family planning, dental, pharmacy, and transportation do not require PMP authorization. Providers are paid a

per member per month case management fee and medical services are paid on a FFS basis.

- Under the RBMC delivery system, the State contracts with managed care organizations (MCOs) to provide comprehensive preventive and primary care services. MCOs are paid a capitation rate per member per month. The MCOs then contract directly with PMPs and other providers either under a capitation or a FFS arrangement. Certain services, including dental services and services delivered by mental health providers, are not covered under the capitation rate.

- When members first become eligible for Hoosier Healthwise managed care, there is an initial period of time referred to as the "Fee-For-Service" (FFS) window. During this time period, members are covered by Hoosier Healthwise but are not yet enrolled in a managed care program (PCCM or RBMC). The FFS window allows members time to review their coverage options and to select a PMP. It also provides time for the selected physician to receive notification about his/her selection as the member's PMP. This FFS window accounts for the majority of members and utilization identified as FFS within this evaluation. Within the FFS system, a member can receive services from any doctor participating in the Hoosier Healthwise program. The Hoosier Healthwise program enrolls children in either the PCCM or RBMC delivery systems so that they may be linked with a PMP.

The selection of a primary medical provider determines the delivery system from which a child receives services. For example, when children are determined eligible for Hoosier Healthwise, their family selects a primary medical provider (referred to as a PMP). The child is then enrolled in the delivery system in which the PMP participates. Therefore, the delivery system under which children receive services is relatively transparent to the members.

Who administers Indiana's CHIP?

The State's Family and Social Services Administration (FSSA) has a number of divisions involved in the operation of Indiana CHIP:

- The Office of the Children's Health Insurance Program (the CHIP Office). Public Law 273-1999, the legislation authorizing Phase II of CHIP, created the CHIP Office and charged them with the responsibility of designing and administering Phase II.

- The Office of Medicaid Policy and Planning (OMPP) is the designated single state agency for Medicaid. The Hoosier Healthwise program is operated by the Managed Care unit of the OMPP.

- The Division of Family and Children (DFC). CHIP eligibility determination is conducted by the DFC.

SECTION III
ENROLLMENT, UTILIZATION AND EXPENDITURE FINDINGS

INTRODUCTION

This section of the report provides detailed information on enrollment and utilization trends. In addition, this section presents the results of analyses of expenditures from the perspective of which services are being purchased in general as well as payments made on a per member per month (PMPM) basis. For each of the analyses, trends across the following populations were evaluated:

- Children in CHIP Phase I
- Children in CHIP Phase II
- Children in CHIP Phases I and II combined
- Children in Medicaid

It should be noted that children in Medicaid were included for comparison purposes. Throughout this report, the term "Medicaid" refers only to the children in Medicaid that are eligible to participate in managed care.

Service utilization and payment trends were analyzed for these populations across multiple dimensions including:

- Expenditures per member per month (PCCM and FFS claims only)
- Utilization on a claims per 1,000 eligibles basis (all delivery systems)
- Utilization on a claims per 1,000 eligibles basis by delivery system (CHIP only)
- Expenditures by age group (PCCM and FFS claims only)

Services covered under the RBMC system are not included in the expenditure analyses because managed care entities are paid a capitation rate per member per month and their claims do not reflect payments on a per service basis. However, the managed care entities in the RBMC system are required to submit to the State details on all of the services they have provided, even though they do not contain payment information on them. These claims, commonly referred to as "shadow claims", are included in the utilization analyses mentioned above.

The paid claims from the PCCM and FFS systems and shadow claim from the RBMC system evaluated for this report represent services utilized during the period from January 1, 2000 through December 31, 2002. Because of the timing of this report, not all claims for the latter half of calendar year 2002 may be represented because providers are still submitting claims for payment. This is especially true for inpatient hospitalization claims. Therefore, throughout this section, when utilization trends are shown graphically, it should be noted that the latter portion of this trend might be underestimated due to the incompleteness of the data.

COMPARISONS TO THE 2002 REPORT

Key trends in enrollment, utilization and payment compared to last year's report can be summarized as follows:

- Enrollment. Indiana continued to enroll children in CHIP at a pace that was similar to the prior year. From December 2001 to October 2002, the enrollment in CHIP Phase I grew 14% (versus 13% in the prior year) for children in families with incomes of 100%-150% of the federal poverty level. Enrollment in CHIP Phase II grew 35% (compared to 40% in the prior year) for children in families with incomes of 150%-200% of the federal poverty level.

- Member Retention. The average number of months that CHIP members remained in the program decreased from 2001 to 2002. For CHIP children overall, average number of months of enrollment fell from 6.8 months in 2001 to 6.3 months in 2002. This is lower than the number of months of enrollment for children in the Medicaid program, which was 9.4 months in 2001 and 9.3 months in 2002. For a recent 12-month period, over 40% of children who enrolled as members were no longer enrolled one year after their start date.

- Method of Service Delivery. A larger percentage of CHIP children were enrolled in the managed care portion of the program (PCCM and RBMC) in 2002 than in 2001. For CHIP Phase I, enrollment in managed care grew from 83% to 91% of all members from 2001 to 2002; for CHIP Phase II, the managed care enrollment increased from 70% to 82%. Having more children in enrolled in managed care versus FFS (the non-managed care program) ensures that children have a "medical home" and allows for better coordination of their care.

- Percentage of Members Using Services. The percentage of CHIP enrollees who used particular services (specifically hospital, physician, dental and pharmacy) as compared to the total number of enrollees who were eligible to use the services remained steady between 2001 and 2002. Also, the percent of CHIP members using these services was slightly lower than that of children in the Medicaid program (except for dental services). Further, when compared to other states, Indiana's children in Hoosier Healthwise access these services at the same or higher rate than those in neighboring states or the national averages.

- Overall Service Expenditures Per Member Per Month (PMPM). The PMPM expenditures for CHIP members in PCCM and FFS increased 0.9% from 2001 to 2002 whereas the corresponding PMPM expenditures for Medicaid children increased 6.7% during this time period. The actual PMPM expenditures for CHIP members

($89 in 2002) continues to be lower than Medicaid children ($111 in 2002) on core services (hospital, physician, dental, pharmacy). Furthermore, the PMPM expenditures for CHIP Phase II ($85 in 2002) are lower than for CHIP Phase I ($89 in 2002).

- Inpatient Hospitalization. Children in CHIP continue to have lower utilization of inpatient hospital care than their counterparts in Medicaid as has been the case for the last three years. As a result, monthly PMPM expenditures for inpatient hospital services remain 75% lower for CHIP children than Medicaid children in 2002 as they were in 2001.

- Outpatient Hospital Services. Like inpatient hospital services, children in CHIP utilize outpatient hospital services less than children in Medicaid. The PMPM expenditures for CHIP members have remained steady from 2001 to 2002 and are even lower than the Medicaid PMPMs for this service in 2002 than they were in 2001. As seen in prior years, there is little difference in average payments for services by age group.

- Physician Services. For primary medical provider (PMP) services, children in CHIP Phase I continued to use this service less than children in Medicaid in 2002, which continued the trend found in 2001. For CHIP Phase II children, however, utilization of PMP services increased in 2002 to the level of Medicaid children. PMPM expenditures for primary care services also remained about $2 lower for CHIP members than Medicaid members in 2002 as they were in 2001.

  Utilization and PMPM expenditure trends for other physician services (non-PMP) remained similar in 2002 to their 2001 levels.

- Pharmacy Services. Children in CHIP Phase I, Phase II and Medicaid continue to use pharmacy services at the same rate. As was found in last year's report, there appears to be a seasonal factor of increased pharmacy utilization in the winter months. Expenditures on a PMPM basis for CHIP Phase I and Medicaid remained similar throughout 2001 and 2002 while CHIP Phase II PMPM expenditures remained below the others by $5 to $10 per month. Further, the average payment per claim for CHIP Phase II children remained the same from 2001 to 2002; however, the average for CHIP Phase I went up 9% during this time.

- Dental Services. Children in CHIP continued to use dental services at a higher rate than children in the Medicaid program in 2002. Specifically, children in CHIP Phase II are using services more often than children in CHIP Phase I, but the PMPM expenditures for both groups are the same. Also similar to last year's findings, the average payments per claim for dental services were highest among children ages 13-18 for CHIP and Medicaid.

ENROLLMENT

This section analyzes enrollment patterns of CHIP children as well as Medicaid children (for comparison purposes) across multiple criteria, including growth year-to-year, average number of months of enrollment in the program, and distribution by age groups, delivery system of care, and urban/rural county status. A study of re-enrollment as well as comparisons of Indiana's uninsured children rate versus other states is also included.

How successful has Indiana's CHIP program been in terms of enrolling eligible children?

Indiana has been very successful in enrolling children into CHIP. The State met its objective to enroll 40,000 previously uninsured low-income children by September 30, 1999. Since meeting this objective, the State has made additional progress related to enrolling uninsured low-income children:

- There were 100,600 children who obtained health insurance through Indiana's Medicaid expansion portion of the program (CHIP Phase I) at some point during 2002. Of these, there were 54,000 children enrolled on October 31, 2002.

- There were 23,200 children who obtained health insurance through Indiana's State-designed portion of the program (CHIP Phase II) at some point during 2002. Of these, there were 12,900 children enrolled on October 31, 2002.

Note: Due to a lag time in processing enrollment applications which then get updated in the automated data system, October 2002 was used because it reflects the most complete month of enrollment counts available.

How does Indiana's child uninsurance rate compare to the U.S. average and nearby states?

Indiana's uninsurance rate for children age 0 through 18 is similar to the national average but near the higher end when compared to states in the region. Conversely, the percentage of children with employer-based coverage is among the highest in the region.

Exhibit III.1
Distribution of Children Aged 0 to 18 by Insurance Status

	U.S.	Indiana	Illinois	Kentucky	Michigan	Ohio	Minnesota	Wisconsin
Employer-based	61%	70%	66%	65%	70%	68%	75%	74%
Individual policies	4%	5%	4%	3%	3%	3%	6%	4%
Medicaid/CHIP	22%	14%	18%	23%	20%	19%	14%	17%
Uninsured	12%	11%	11%	10%	7%	9%	6%	5%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured
Estimates based on pooled March 2001 and 2002 Current Population Surveys (U.S. Census Bureau).
Total U.S. numbers are based on March 2002 estimates.

What is the growth rate in 2002 of the CHIP Program (Phases I and II)?

As of October 2002, there were approximately 446,700 children under the age of 19 enrolled in Indiana's Hoosier Healthwise program. Of this, 85% of all beneficiaries were in the Medicaid program and 15% were in the CHIP program. With Indiana's phase-in approach to CHIP implementation, overall Hoosier Healthwise enrollment figures have been steadily increasing since 1997. However, as January 2000 marked the final phase of CHIP implementation (CHIP Phase II), the overall rate of program growth has slowed. CHIP enrollment increased 6% over the course of 2001 and again in 2002 (see Exhibit III.2 below). This is reflected in steady enrollment in CHIP Phase I and an increase in enrollment in CHIP Phase II.

Exhibit III.2
Total CHIP Enrollment & Annual Growth Rate

Year	CHIP Phase I	CHIP Phase II	Combined Enrollment	Combined Growth Rate
December, 1998	36,400	--	36,400	--
December, 1999	45,400	--	45,400	24%
December, 2000	52,500	6,800	59,300	30%
December, 2001	53,500	9,600	63,100	6%
October, 2002	54,000	12,900	66,900	6%

Note: Due to a lag time in processing enrollment applications which then get updated in the automated data system, October 2002 was used because it reflects the most complete month of enrollment counts available.

Source: Dataprobe files through December 2002

Why is the enrollment in CHIP Phase II increasing at a faster rate than CHIP Phase I?

Historically, children in the Phase I of CHIP were comprised of two unique groups—those children (all teenagers) that enrolled October 1, 1997 that were previously not eligible for Medicaid, and those children that enrolled on or after July 1, 1998 whose families earn between 100% and 150% of the federal poverty level. To be eligible for CHIP, the teenagers in the first group had to be born before October 1, 1983. The last of these children "aged out" of CHIP in September, 2002. However, as this portion of the CHIP Phase I population has been declining, the enrollment growth for children in the remaining portion of Phase I has been outpacing the decline of the first group. Therefore, it is anticipated that the enrollment in CHIP Phase I will rise at a faster rate in the next few years than shown historically because there is no longer a large group of enrollees that will be leaving the program due to age. Meanwhile, enrollment in CHIP Phase II continues to show larger increases (see Exhibit III.3 on the next page).

Exhibit III.3
Growth Rates of CHIP Members by Family Income Levels

Year	CHIP Members Phase I (100% - 150% of FPL)	CHIP Members Phase II (150% - 200% of FPL)	Growth Rate CHIP Phase I	Growth Rate CHIP Phase II
December, 2000	41,700	6,800	--	--
December, 2001	47,400	9,600	13%	40%
October, 2002	54,000	12,900	14%	35%

Note: Due to a lag time in processing enrollment applications which then get updated in the automated data system, October 2002 was used because it reflects the most complete month of enrollment counts available.

Source: Dataprobe files through December 2002

How does the average length of program participation of members compare between CHIP Phase I, CHIP Phase II and Medicaid?

The average number of months children are enrolled is relatively similar across all age groups for both phases of CHIP, although length of program participation for members in CHIP Phase II is slightly lower in the older age groups. However, both CHIP phases have average enrollment periods that are lower than average enrollment periods for children in the Medicaid program, especially in the one and five age group. Also, it should be noted that the average tenures for all programs and all age groups remained the same or decreased between 2001 and 2002. This may reflect the elimination of 12-month continuous eligibility for children (see Exhibit III.4 on the following page).

Exhibit III.4
Average Tenure By Program and by Age Group (in months)

	For all enrollees with eligibility in Calendar Year 2001		
	Age 1 - 5 Years	**Age 6 - 12 Years**	**Age 13 and over**
CHIP Phase I (teens aging out)	N/A	N/A	6.6
CHIP Phase I (all others)	6.2	7.2	6.7
CHIP Phase II	5.9	6.3	6.1
Medicaid	10.2	9.7	8.3

	For all enrollees with eligibility in Calendar Year 2002		
	Age 1 - 5 Years	**Age 6 - 12 Years**	**Age 13 and over**
CHIP Phase I (teens aging out)	N/A	N/A	4.6
CHIP Phase I (all others)	5.7	6.7	6.2
CHIP Phase II	5.5	6.0	5.6
Medicaid	10.0	8.8	7.7

Source: Dataprobe files through December 2002

How does the age distribution of members in CHIP Phase I compare to the distribution in CHIP Phase II and Medicaid?

There is less variation in age distribution between CHIP Phase II and Medicaid than there is between CHIP Phase II and CHIP Phase I. Given that the large teenage group in the original implementation of CHIP Phase I recently became too old to participate in the program, it is expected that CHIP Phase I would have a greater share of teenagers. As this subgroup has aged out of the program, the distribution of children in CHIP Phase I has become more similar to CHIP Phase II. In calendar year 2002, the two CHIP programs had the largest share of children in the age 6-12 group while the Medicaid program had its largest share in the 0-5 age group. Differences in the distribution by age may yield different per member per month expenditure trends between the three groups because the services delivered to different age groups of children can vary (see Exhibit III.5 on the next page).

Exhibit III.5
Age Distribution of Children Age 0-18 by Program Type in 2001

Age Group	CHIP Phase I	CHIP Phase II	Medicaid
Age 0 to 5	12%	36%	47%
Age 6 to 12	46%	41%	35%
Age 13 to 18	42%	23%	18%
Average Age	11.8 years	8.6 years	7.0 years

Age Distribution of Children Age 0-18 by Program Type in 2002

Age Group	CHIP Phase I	CHIP Phase II	Medicaid
Age 0 to 5	13%	36%	46%
Age 6 to 12	52%	40%	34%
Age 13 to 18	35%	24%	20%
Average Age	11.0 years	8.7 years	7.5 years

Source: Dataprobe files through December 2002

What is the distribution of enrollment by delivery system between CHIP Phase I, CHIP Phase II, and Medicaid members?

The Hoosier Healthwise program (both CHIP and Medicaid) has made a concerted effort in the past year to enroll more children in the Risk-Based Managed Care (RBMC) delivery system. Under this system, members are enrolled with doctors who are affiliated with managed care entities. This system, in conjunction with the Primary Care Case Management (PCCM) delivery system, comprises Indiana's managed care program. Since July 2002, about 90% of the children enrolled in Hoosier Healthwise were in the managed care program. The remaining 10% were in the Fee-for-Service (FFS) portion of the program. There are two primary reasons why children may be enrolled in the FFS portion of the program:

- They are in the FFS system for a temporary period when first enrolling in Hoosier Healthwise before they have chosen a doctor (commonly referred to as the "fee-for-service window")
- They are affiliated with doctors in rural areas of the state where there is less managed care participation

It is the goal of the State for children to have a PMP through enrollment in the managed care portion of the program. In 2002, mandatory enrollment in Risk Based Managed Care was implemented in five counties, as required by State law:

- Allen County (effective 4/1/02)
- Marion County (effective 4/1/02)
- Elkhart County (effective 7/1/02)
- St. Joseph County (effective 7/1/02)
- Lake County (effective 10/1/02)

Approximately 13% of all CHIP Phase I and Phase II members moved to the RBMC system as a result of the implementation of mandatory managed care in the counties named above. As seen in Exhibit III.6 below, because of this mandatory transition to managed care in conjunction with new enrollees joining into RBMC directly, the distribution between the three delivery system models saw significant change between 2001 and 2002.

Exhibit III.6
Percentage of Members Enrolled by Delivery System
December 2001 and December 2002

Year	Program Type	PCCM	RBMC	FFS
2001	CHIP Phase I	64%	18%	17%
	CHIP Phase II	56%	14%	31%
	Medicaid	59%	25%	16%
2002	CHIP Phase I	52%	39%	9%
	CHIP Phase II	46%	37%	18%
	Medicaid	43%	46%	11%

Source: Dataprobe files through December 2002

What are the Urban/Rural distribution patterns of CHIP Phase I and II versus Medicaid enrollment for children? Have they changed since last year?

The majority of beneficiaries in each program live in an urban area. The urban/rural distribution at the end of 2002 was the same as at the end of 2000 and 2001 with 81% of the CHIP population (Phase I and Phase II) and 86% of the Medicaid population residing in urban counties.

How successful has Indiana been in maintaining members in its CHIP/Medicaid programs?

Two studies of retention and disenrollment—one completed early on in the CHIP program and one more recently—have been conducted to study the impact of children who remain enrolled after their first year in the program. The more recent study focused on those members that

enrolled for the first time in either the Phase I (Medicaid expansion, lower FPL level) or Phase II (State-designed, higher FPL level) programs of CHIP between July 1, 2000 and June 30, 2001. These members were tracked from their initial enrollment to December 31, 2002 to determine:

- How many did not have a lapse in enrollment?
- How many had a lapse in enrollment but returned to the program?
- How many dropped out of the program and did not return?

This evaluation tracked members over a period greater than 12 months to determine if there was a high incidence of members dropping after the 12th month of enrollment (i.e. the period in which they need to re-enroll). The distribution of members staying in or dropping out of the program were found to be similar in both phases of CHIP:

Exhibit III.7
Enrollment Status After One Year of Eligibility
For CHIP Members Who Started Enrollment Between 7/1/00 and 6/30/01

Enrollment Status	Phase I Members	Phase II Members
No lapse in eligibility	44%	44%
Lapse in eligibility but returned	15%	13%
Eligibility ended with no return	41%	43%

Note: Children who "aged out" of CHIP (turned age 19) were excluded from this analysis.

Source: Dataprobe files through December 2002

The findings from this more recent study are similar to those earlier in the history of the program. Disenrollment patterns for Indiana's CHIP members are similar to those of children in the Medicaid program. Nationwide, there has been little research conducted to determine why the disenrollment rates after the initial enrollment period seem to be relatively high, but initial studies show that Indiana's trends are similar to other states' experiences. Colorado shows disenrollment trends at 40 percent as well and New York experienced disenrollments which varied from 25 to 50 percent depending upon health plan (*Source: Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program, Mathematica Policy Research et al, February 26, 2003*).

Since July 1, 2002 Indiana's policy of continuous eligibility for children was discontinued. Prior to this period, children were enrolled for 12 months even if their family's income exceeded thresholds mid-year that would have made them ineligible if they were just applying. This change in policy may lead to a decrease in the number of eligible children in coming years. This facet of retention will continue to be monitored.

SERVICE UTILIZATION AND EXPENDITURES

An analysis of claims was completed to:

- Determine if members are using services at the overall expected rate (e.g. comparing utilization by children in CHIP Phase I, CHIP Phase II and the Medicaid program)

- Determine if there are differences in utilization patterns between the PCCM, RBMC and FFS delivery systems

- Determine if differences in per member per month expenditures between CHIP Phase I, CHIP Phase II and Medicaid children are a result of differing utilization patterns or the cost of services

- Determine if there are differences in expenditure patterns between age groups to better understand what may drive differences between the CHIP and Medicaid utilization and expenditures. Past evaluations found that the composition of the ages within a program (e.g. more teenagers in CHIP Phase I, more infants in Medicaid) often drove differences in both utilization and payment.

Utilization and expenditure trends were studied for four types of services:

- Hospital services (including inpatient and outpatient)
- Physician services (including those designated as Primary Medical Providers and those who are not)
- Pharmacy scripts
- Dental services

To capture utilization trends for specific time periods, EP&P evaluated utilization and expenditures based upon the date when the service was received, not when the service was paid for by the State. As a result, not all claims for the latter half of calendar year 2002 are represented because providers are still submitting claims for payment. This is especially true for hospital claims. Therefore, utilization and payment charts only reflect trends through the month of October 2002 so as not to artificially skew the findings.

Do utilization statistics indicate that CHIP members are accessing services?

Overall, CHIP members in the Phase I and Phase II portions of the program are accessing services at similar rates. The number of unique individuals enrolled in both CHIP phases for the PCCM and FFS delivery systems was measured and compared to the number of unique individuals that actually accessed services. This review was conducted separately for the following services—inpatient hospital, outpatient hospital, physicians serving as primary medical providers (PMPs), other physicians that are not PMPs (non-PMPs), pharmacy, and dental services. The evaluation also compared these statistics to the children in the Medicaid program. Key findings from this analysis, as displayed in Exhibits III.8 – III.10 on the following pages, indicate:

- About two-thirds of all CHIP Phase I and II members accessed some service in both 2001 and 2002. This is slightly less than the percentage of Medicaid children accessing the same services.

- The most common service used in both CHIP and Medicaid is pharmacy services. About half of all enrollees in both programs had a pharmacy script in CY 2001 and 2002.

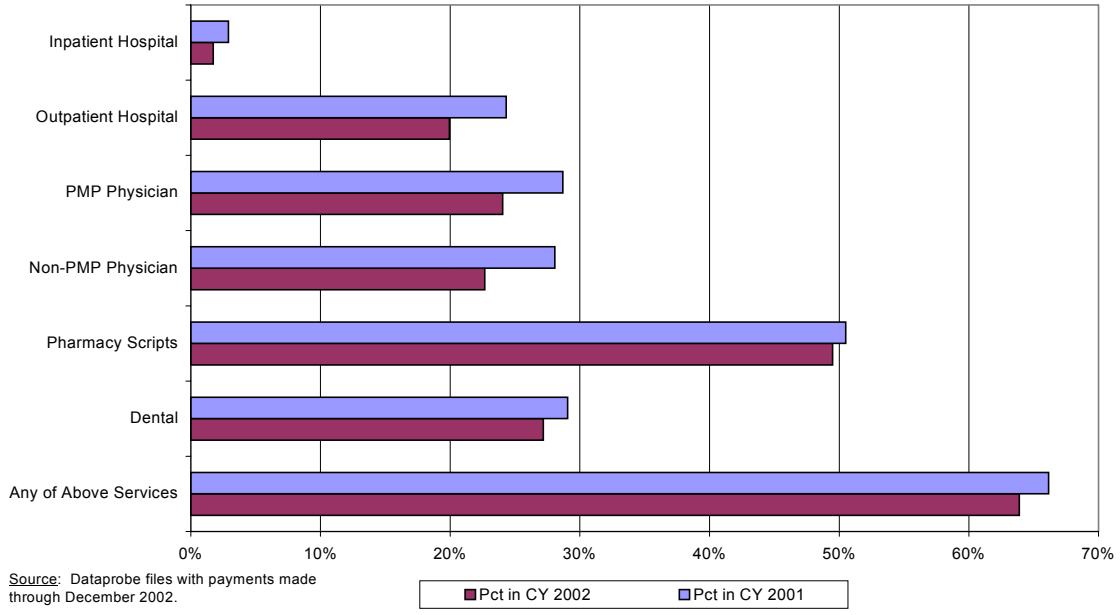
- Children in CHIP Phase II were slightly more likely to access physician services than their counterparts in CHIP Phase I but slightly less likely than Medicaid children.

- Children in Medicaid are more likely to use inpatient and outpatient hospital services than children in CHIP.

- Although it appears for both CHIP and Medicaid that there were lower percentages of children using services in CY 2002 than CY 2001, the figures for 2002 are most likely understated because not all claims have been submitted to the State yet. The small differences between the two years for both programs implies that the percentage of users remained relatively constant across the two years.

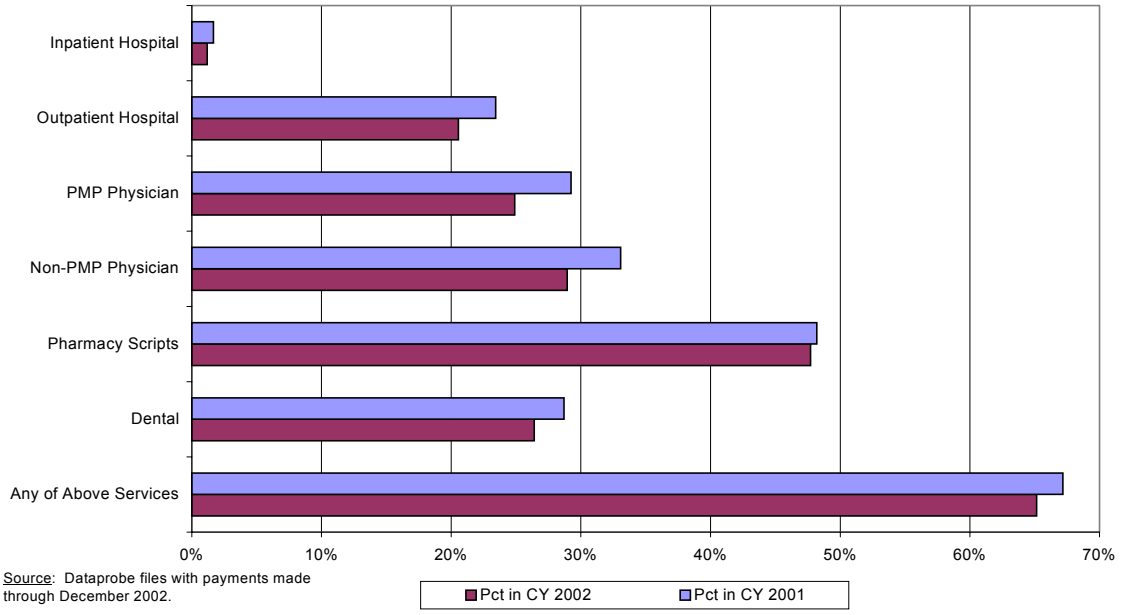
It should be noted that there are other services available to CHIP members that have not been included in the analysis shown below (e.g. clinic services, nursing facility). The exhibits show that about 66% of children accessed at least one of the services listed on the exhibit. When all other services available to CHIP members are also included, the percentage that accessed *any* service rose to about 78%.

Exhibit III.8
Percent of CHIP Phase I Enrollees that Used Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



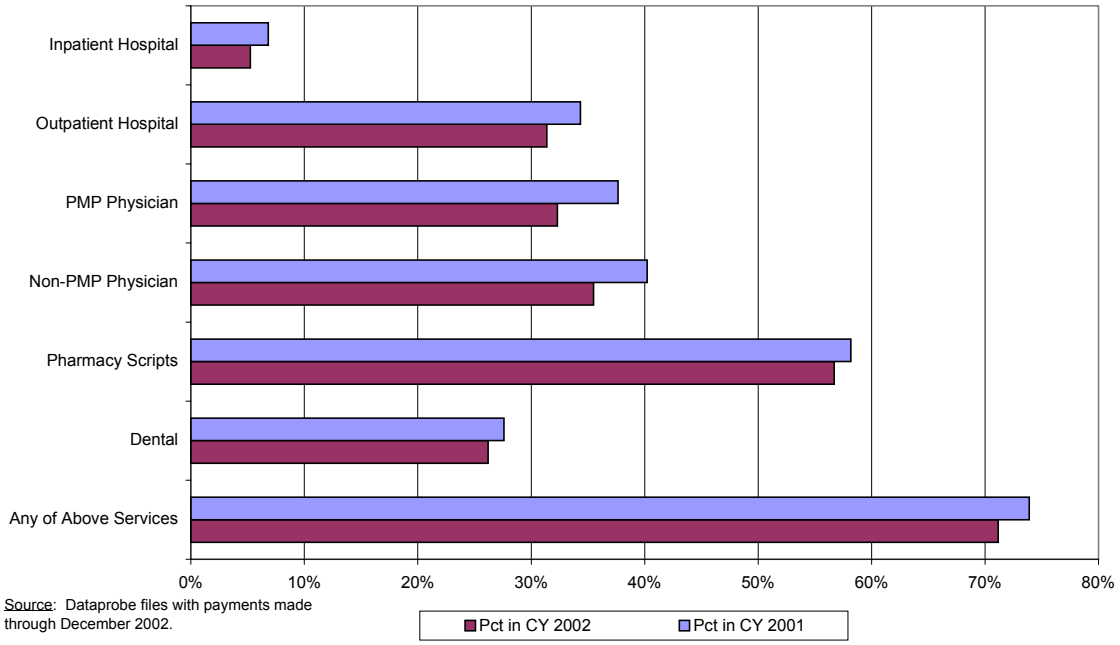
Source: Dataprobe files with payments made through December 2002.

Exhibit III.9
Percent of CHIP Phase II Enrollees that Used Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: Dataprobe files with payments made through December 2002.

Exhibit III.10
Percent of Medicaid Enrollees that Used Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: Dataprobe files with payments made through December 2002.

How does Indiana's utilization statistics for children compare to those of other states?

The percent of children in Indiana's Medicaid program that used key services was compared to other states' information to determine how Indiana's trends relate to peers and national averages. The states compared to Indiana are its border states and those in its CMS region—namely Illinois, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin. The data for comparison consisted of information that states are required to report to CMS (MSIS data) for the period of FFY 2000 (the most recent year available). Data reported for children in Medicaid was used as a proxy for CHIP data due to the variation in eligibility categories across the states' CHIP programs and the relative newness of the programs in FFY 2000. However, as previously stated, the utilization of CHIP members was similar to that of Medicaid children. The comparison across states showed that:

- When compared to national averages, Indiana's children had a higher rate of utilization services for inpatient hospital, outpatient hospital, physician, pharmacy, and dental services.

- When compared to its peers, Indiana's children had the highest rate of utilization for inpatient hospital, physician, and dental services.

- For outpatient hospital and prescription drugs, Indiana's children had a utilization rate that was in the middle compared to its peers.

Exhibit III.11
Percent of Medicaid Child Enrollees that Used Services
Based on Unique Number of Eligibles in Non-Managed Care Delivery Systems

	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Prescribed Drugs	Dental Services
	Percent Using Service	Percent Using Service	Percent Using Service	Percent Using Service	Percent Using Service
United States	6%	23%	36%	38%	16%
Indiana	8%	27%	51%	48%	28%
Illinois	5%	35%	48%	51%	0%
Kentucky	4%	30%	47%	52%	21%
Michigan	4%	9%	18%	16%	24%
Minnesota	3%	11%	20%	17%	7%
Ohio	8%	31%	46%	41%	17%
Wisconsin	3%	13%	10%	21%	16%

Source: MSIS Data for Federal Fiscal Year 2000, CMS Website

How do expenditures for CHIP children compare to Medicaid children?

Prior annual evaluation reports found that differences in expenditures for services between CHIP and Medicaid was usually based on different utilization patterns of members due to each program serving different age groups of children. For example, CHIP Phase I has experienced a higher percentage of total expenditures in pharmacy scripts due to the higher concentration of teenagers who were also found to have more expensive scripts on a per claim basis than younger children.

Expenditure patterns were reviewed for calendar years 2000, 2001 and 2002 in the PCCM and FFS delivery systems for services widely used by members. The total expenditures for each service type were compared across three years within each program (CHIP Phase I, CHIP Phase II, and Medicaid) to determine if there have been shifts in expenditures between the services over the years. Key findings, as shown in Exhibit III.12, include:

- The service accounting for the largest percentage of expenditures varied for each program. For CHIP Phase I, pharmacy scripts accounted for the greatest percentage of expenditures; for CHIP Phase II, dental services were greatest; for Medicaid, inpatient services were greatest.

- Compared among these main service categories, the percentage of expenditures for inpatient hospital services has declined for every program while the percentage of outpatient hospital expenditures has remained steady or slightly declined.

- Sharp increases have occurred in pharmacy expenditures, and dental expenses as a percentage of the total have increased for each program.

- The percentage of expenditures for physician services (both PMP and non-PMP) as a percentage of the total has remained relatively constant in each program.

Exhibit III.12
Total PCCM and FFS Expenditures
For Calendar Years 2000, 2001 and 2002
By Program and Service Category

	CHIP PHASE I PROGRAM					
	Calendar Year 2000		Calendar Year 2001		Calendar Year 2002	
Category of Service	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total
Inpatient Hospital	$12,510,700	28.0%	$11,350,400	24.1%	$6,641,700	18.2%
Outpatient Hospital	$5,294,100	11.9%	$5,613,500	11.9%	$3,767,600	10.3%
Pharmacy Scripts	$10,248,700	23.0%	$12,674,300	26.9%	$11,500,000	31.5%
PMP Physician	$2,739,100	6.1%	$2,777,900	5.9%	$1,937,900	5.3%
Non-PMP Physician	$4,237,400	9.5%	$4,128,800	8.8%	$2,929,900	8.0%
Dental	$9,611,600	21.5%	$10,586,800	22.5%	$9,681,900	26.6%
Total	**$44,641,600**	**100.0%**	**$47,131,700**	**100.0%**	**$36,459,000**	**100.0%**

	CHIP PHASE II PROGRAM					
	Calendar Year 2000		Calendar Year 2001		Calendar Year 2002	
Category of Service	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total
Inpatient Hospital	$753,000	24.5%	$1,306,000	19.2%	$1,078,800	14.8%
Outpatient Hospital	$467,800	15.2%	$925,200	13.6%	$923,900	12.7%
Pharmacy Scripts	$492,200	16.0%	$1,680,200	24.6%	$1,888,500	26.0%
PMP Physician	$174,400	5.7%	$455,900	6.7%	$448,600	6.2%
Non-PMP Physician	$439,700	14.3%	$749,800	11.0%	$803,200	11.0%
Dental	$745,400	24.3%	$1,702,200	25.0%	$2,130,400	29.3%
Total	**$3,072,500**	**100.0%**	**$6,819,300**	**100.0%**	**$7,273,400**	**100.0%**

	MEDICAID PROGRAM					
	Calendar Year 2000		Calendar Year 2001		Calendar Year 2002	
Category of Service	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total
Inpatient Hospital	$103,125,200	35.6%	$115,129,000	33.5%	$86,799,200	29.3%
Outpatient Hospital	$32,799,400	11.3%	$38,666,100	11.2%	$32,251,200	10.9%
Pharmacy Scripts	$59,153,900	20.4%	$78,915,700	22.9%	$72,808,800	24.6%
PMP Physician	$21,772,700	7.5%	$23,353,300	6.8%	$18,785,000	6.3%
Non-PMP Physician	$29,635,100	10.2%	$33,528,800	9.7%	$27,843,700	9.4%
Dental	$43,022,300	14.9%	$54,408,800	15.8%	$57,509,700	19.4%
Total	**$289,508,600**	**100.0%**	**$344,001,700**	**100.0%**	**$295,997,600**	**100.0%**

Notes

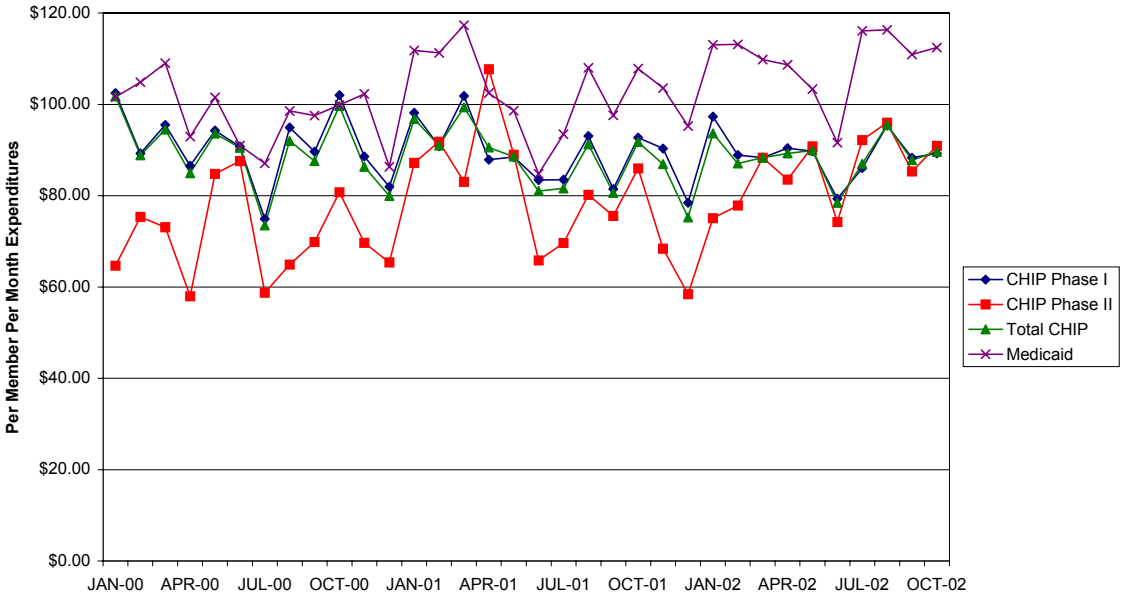
1. Capitation payments made to managed care entities are not included in the above totals.
2. Other services representing a small portion of expenditures are not included above.
3. The totals for the Medicaid group represent expenditures for the children in Medicaid only.
4. All expenditures are categorized by calendar year based upon dates of service.
5. Calendar year 2002 expenditures are artificially low due to a "lag" in claims processing at year-end.

Source: Dataprobe files with payments made through December 2002

Although there are variations in the types of expenditures between CHIP Phase I, Phase II and Medicaid, are there differences in the overall per member per month expenditures?

Yes. When the key services shown in Exhibit III.13 were measured on a per member per month (PMPM) expenditure basis (for the PCCM and FFS populations), it was found that over the last three years that expenditures PMPM were greater for Medicaid children relative to CHIP children. Within CHIP, historically the Phase I children had a slightly greater per-child expenditure than the Phase II children, but since early 2002 the expenditures have been similar. For the entire CHIP program, PMPM costs have been relatively constant between $90 and $100 per month over the last three years.

Exhibit III.13
Per Member Per Month Expenditures (All Major Services)
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

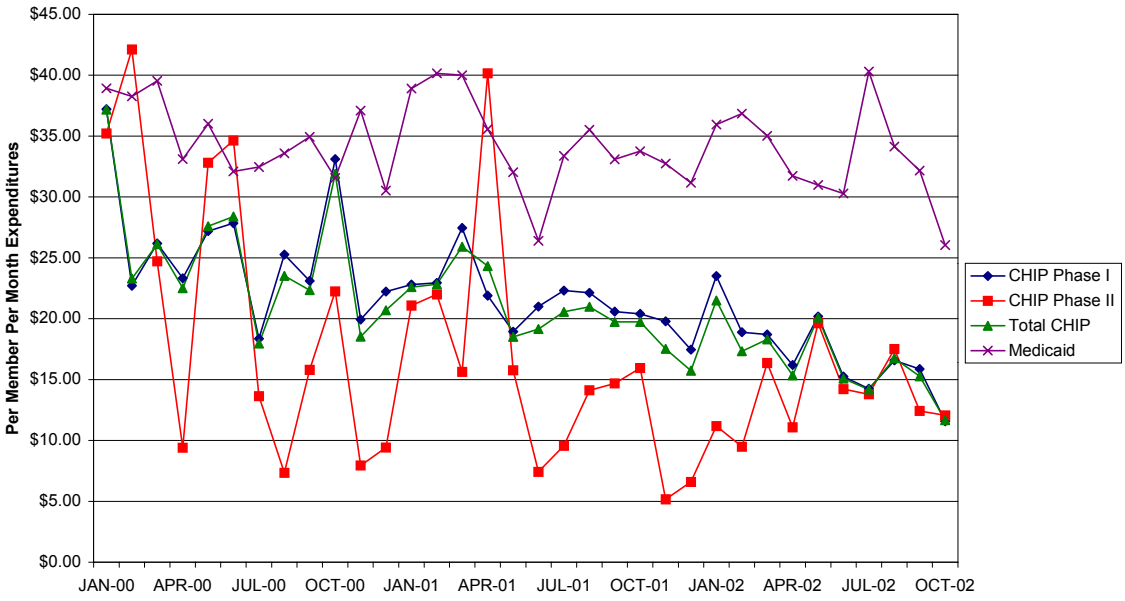
HOSPITAL SERVICES

How do PMPM expenditures compare between CHIP Phase I, Phase II and Medicaid for inpatient and outpatient hospital services?

Although inpatient hospital services are the most expensive types of claims, the PMPM calculations are the most volatile for this service due to the lower volume of total claims. Nonetheless, Exhibit III.14 shows that there is a trend in the PMPM expenditures when compared against the different programs. The PMPM for inpatient hospital services for Medicaid children has historically been about $10 higher per month than the PMPM for the CHIP program (Phase I and II combined). Because of low volume in the early years of the program, CHIP Phase II PMPMs for this service were highly volatile but appear to be similar to CHIP Phase I throughout most of 2002.

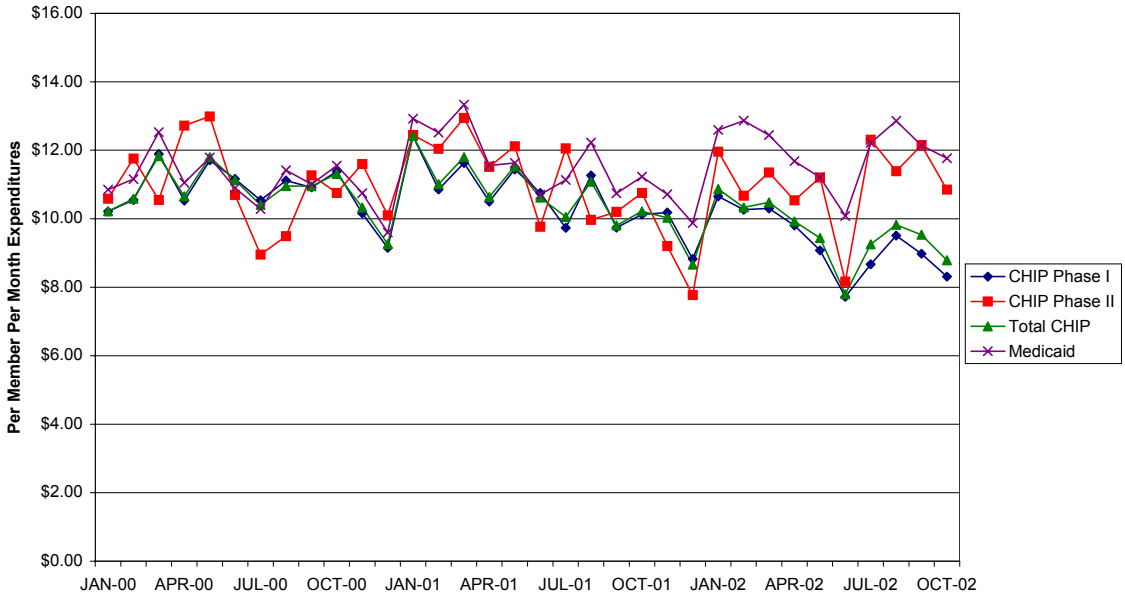
In contrast, outpatient hospital PMPM expenditures have been more stable for all programs and are more closely aligned between $8 and $13 per member per month. The Medicaid PMPMs have been slightly higher over the past three years when compared to CHIP, and CHIP Phase II tends to be slightly higher than CHIP Phase I (see Exhibit III.15).

Exhibit III.14
Inpatient Hospital Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

Exhibit III.15
Outpatient Hospital Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

How does utilization of hospital services differ for children in CHIP and Medicaid?

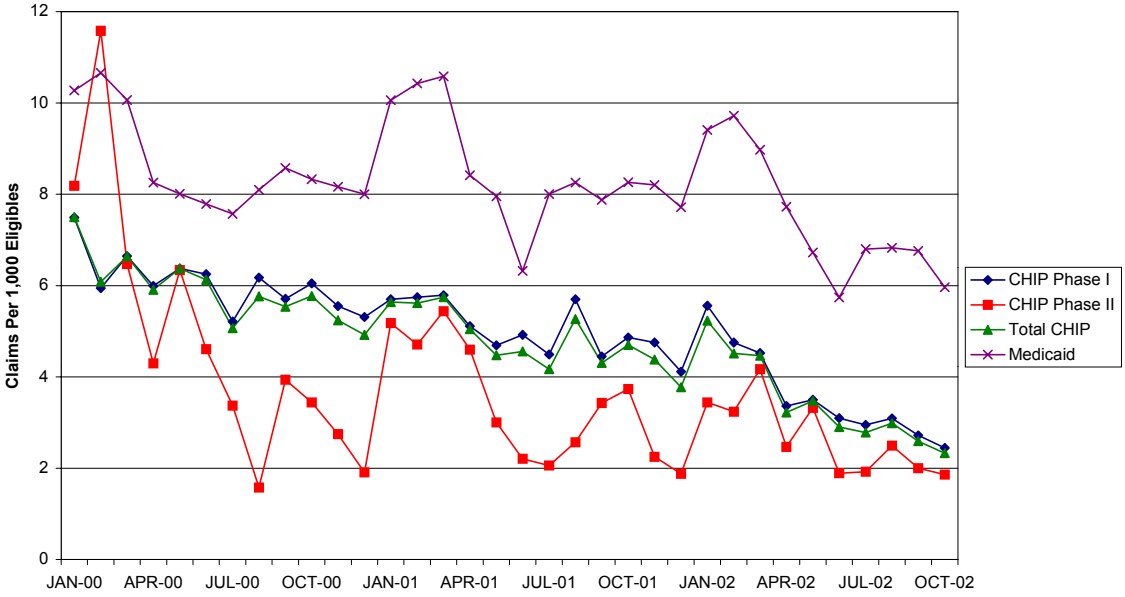
A common method of measuring claims utilization is on a "per 1,000 eligibles" basis. This allows for comparisons between populations of varying sizes, as is the case between CHIP and Medicaid and further between CHIP Phase I and Phase II. Comparing on this basis, the claims per 1,000 eligible trends for hospital services follow similar patterns as the trends for PMPM expenditures, with Medicaid children consistently having a higher utilization of inpatient hospital claims than CHIP members. Also similar to the PMPM trend, CHIP Phase II is resembling CHIP Phase I more closely as the number of members and volume of claims increases for this phase of CHIP (see Exhibit III.16).

Outpatient claims per 1,000 eligibles follow trends similar to inpatient hospital claims. As seen in the PMPM trend, the difference between the higher Medicaid utilization and lower CHIP utilization is widening in 2002. Also, CHIP Phase II utilization is slightly higher than CHIP Phase I (see Exhibit III.17).

Because the utilization trends for inpatient and outpatient services mirror the PMPM trends, it can be inferred that the costs on a per claim basis are relatively stable between the programs and

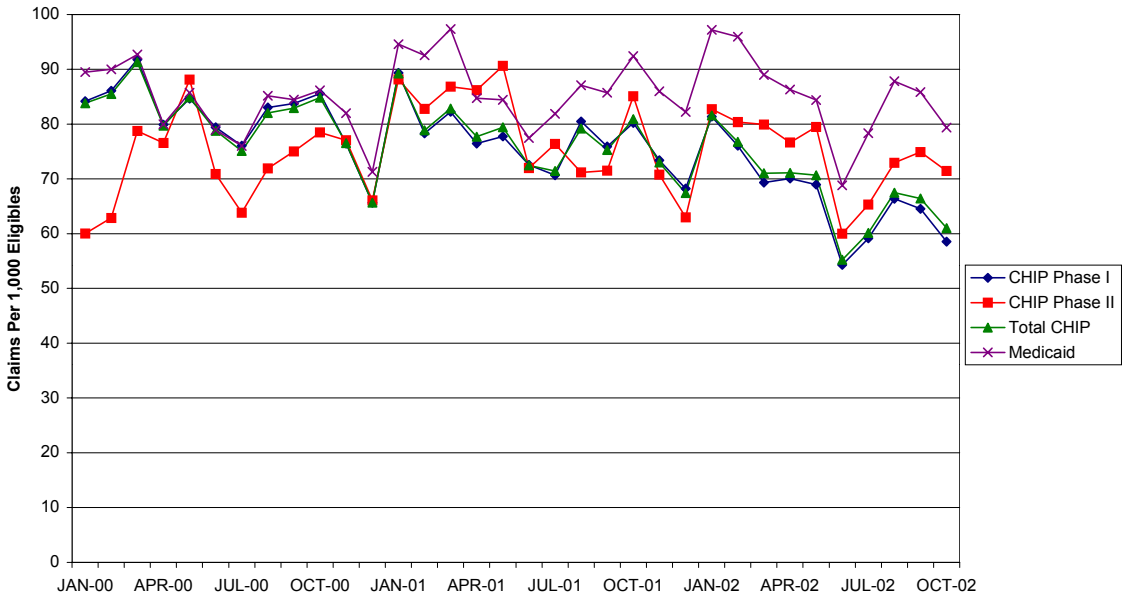
that differences between the PMPM expenditures for CHIP and Medicaid are driven more by volume differences.

Exhibit III.16
Inpatient Hospital Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files through December 2002. Shadow claims (RBMC delivery system) included.

Exhibit III.17
Outpatient Hospital Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files through December 2002. Shadow claims (RBMC delivery system) included.

How does the utilization and payment of hospital services for CHIP members compare across the three delivery systems?

Service utilization and payments for CHIP members (Phase I and Phase II combined) across the three types of delivery systems—PCCM, RBMC and FFS—were examined. With respect to utilization, CHIP members in the FFS delivery system are using more inpatient hospital services than members in the PCCM or RBMC delivery systems. This finding may reflect that higher proportions of new members (who are temporarily in the fee-for-service "window") are often in greater need of hospital services than longer-term enrollees. In addition, the PMPM expenditures for FFS members ($80 to $100 per month) are higher than that for PCCM members ($20 to $30 per month). This trend is changing substantially in 2002, however, as more and more members are being transitioned to the RBMC system, thereby causing the FFS PMPM to decline steadily. (Note: The PMPM for RBMC members was not compared because individual claim payments are not available in this delivery system).

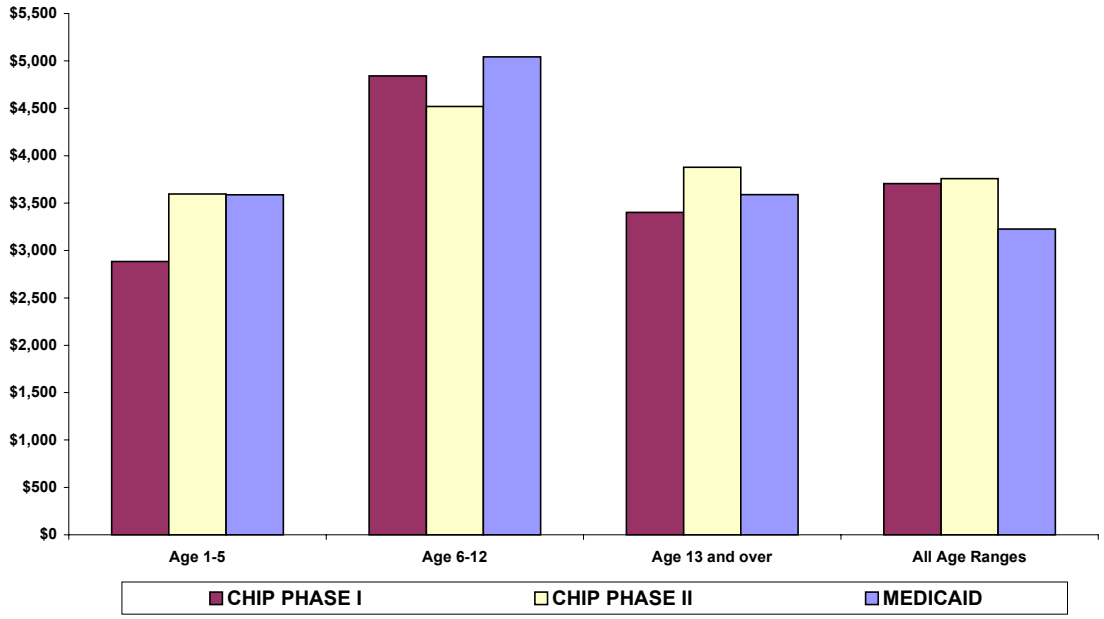
For outpatient services, it was found that utilization for PCCM members actually outpaced that for members in the RBMC and FFS systems. The same trend held true when PMPMs were compared for members in each delivery system.

Are there variations between the costs of hospital services for CHIP and Medicaid members by age group?

For inpatient hospital services in 2002, the payment per claim for CHIP members ($3,700) was almost 15% higher than the average payment per claim for Medicaid members ($3,200). However, payments per claim do vary by age group. For the six through twelve age group, Medicaid average payments are actually higher than CHIP (see Exhibit III.18).

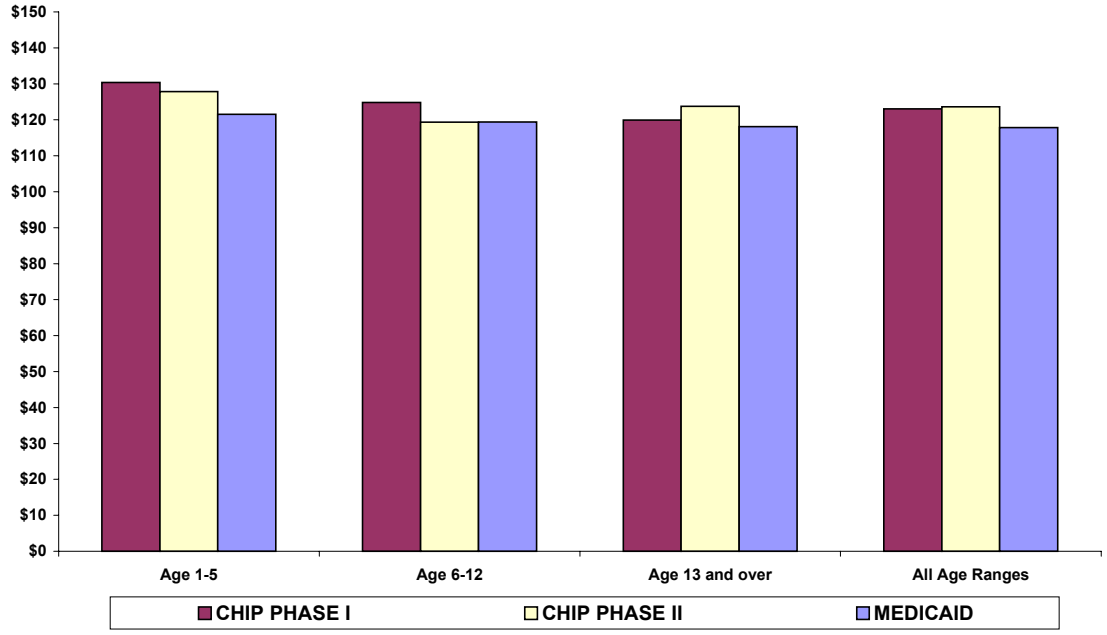
For outpatient hospital services in 2002, there is very little difference in the average payment per claim between CHIP and Medicaid or between the age groups (see Exhibit III.19).

Exhibit III.18
Inpatient Hospital Average Paid Per Claim
For Dates of Service in Calendar Year 2002



Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

Exhibit III.19
Outpatient Hospital Average Paid Per Claim
For Dates of Service in Calendar Year 2002



Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

What are the most common hospitalizations for children in CHIP and Medicaid? Which hospitalizations represent the highest expenditures?

All hospitalizations for CHIP and Medicaid children in 2001 and 2002 were grouped and reviewed by common DRGs (Diagnostic Related Groups). Although it was found that the top DRG group for Medicaid based on the total number of claims also represented the group with the highest expenditures, this was not the case for CHIP. Specific findings showed:

- Claims for neonates ("preemies" or infants with complications) represented 41% of all Medicaid claims in 2001 and 2002 and 30% of all payments.

- The top DRG group based on payments in CHIP was for behavioral health-related hospitalizations, representing 33%-36% of payments in 2001 and 2002. Based on the number of claims, however, this type of hospital claim represented 22%-25% of the total CHIP claims in 2001 and 2002.

- Maternity-related services (the mothers' claims alone) accounted for 25%-35% of all CHIP hospitals but only 12%-15% of all payments in 2001 and 2002.

PHYSICIAN SERVICES

For this analysis, services provided by physicians to CHIP members were classified into two major categories: services provided by a PMP (Primary Medical Provider) and services provided by a physician that is not classified as a PMP. A PMP serves as the coordinator of care for a child in CHIP or Medicaid. In the PCCM delivery system, these PMPs are paid a monthly administrative fee to assume this responsibility. PMPs may include General Practitioners, General Pediatricians, Family Practitioners, OB/GYNs, and General Internists. However, some physicians eligible to be PMPs but who choose not to assume that role provide care to children in CHIP or Medicaid. These physicians may be members of a PMP's group practice. This latter group, in addition to other types of physician specialties, is called "non-PMPs" in the analysis below. One of the reasons for separating these two physician groups is to see the level of utilization and payments to physicians who assume the coordination of care responsibility versus those who do not.

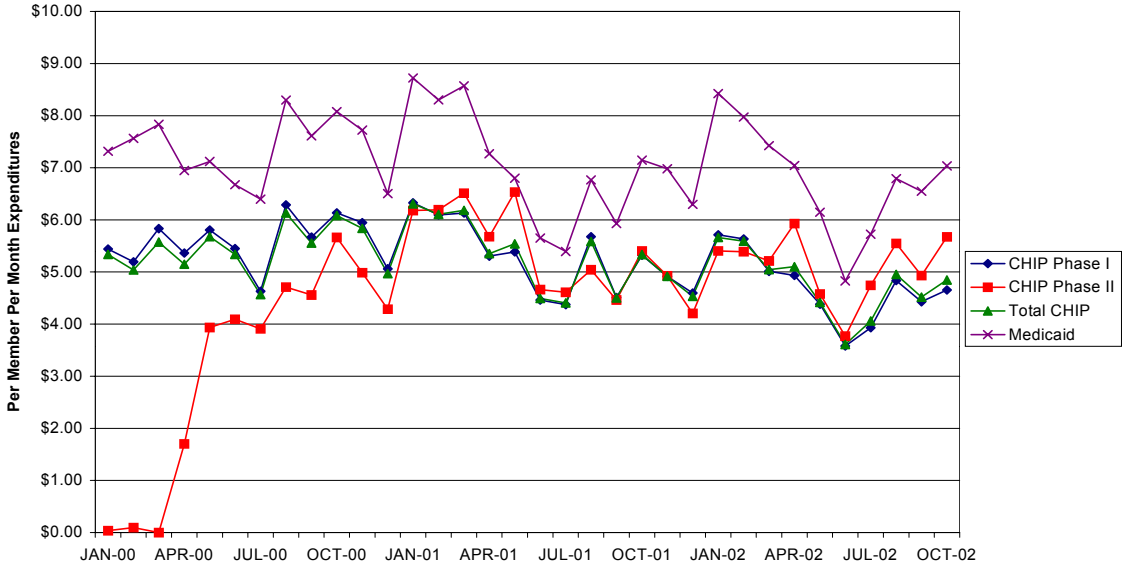
How do PMPM expenditures compare between CHIP Phase I, Phase II and Medicaid for PMP and non-PMP physicians?

The PMPM expenditures for PMP physicians have been relatively stable over the last three years and have followed a similar trend across the programs. The Medicaid PMPM has consistently been $2-$3 higher than the CHIP PMPM. There is little difference between the CHIP Phase I and Phase II PMPMs (see Exhibit III.20).

For non-PMP physicians, the differences between Medicaid and CHIP are the same as for PMP physicians. The Medicaid PMPM has been $10-$11 per month whereas the overall CHIP PMPM has been $8-$9 per month. However, in this service group, CHIP Phase II more resembles the PMPMs for Medicaid than for CHIP Phase I (see Exhibit III.21).

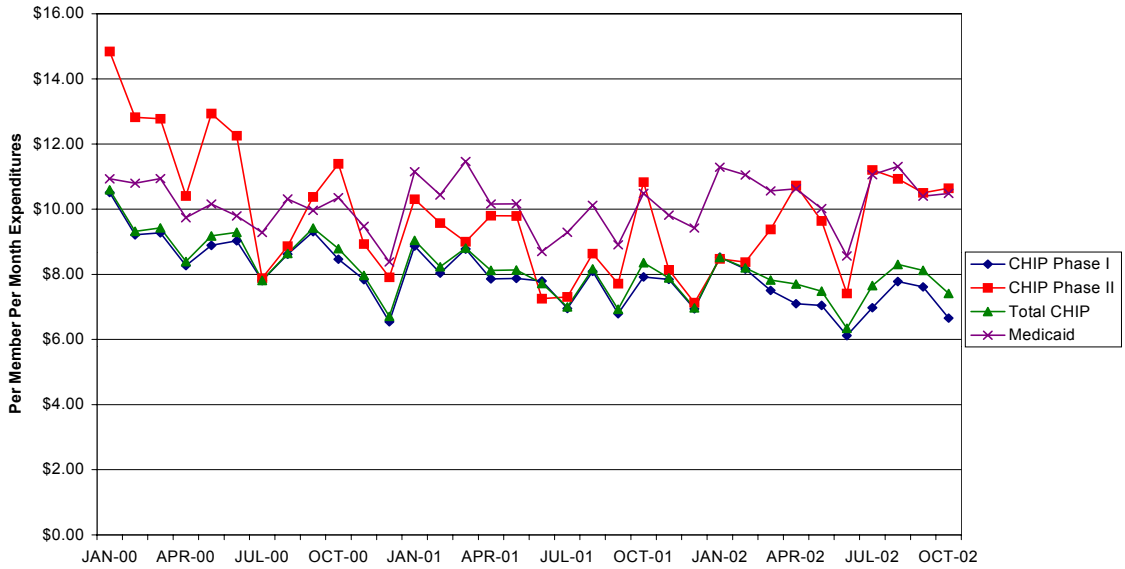
Also, it should be noted that the State is paying about $2 more per member per month on non-PMP services than for PMP services. This may be attributable to the types of specialist physicians that are included in the non-PMP group.

Exhibit III.20
PMP Physician Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

Exhibit III.21
Non-PMP Physician Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



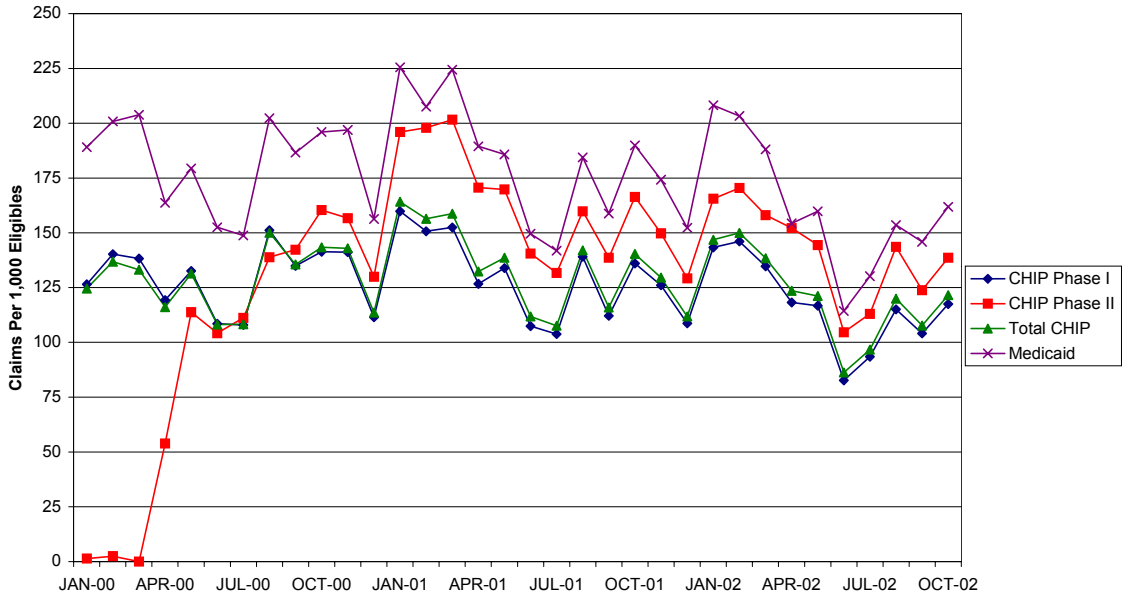
Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

How does utilization of physician services differ for children in CHIP and Medicaid?

As reported in prior annual evaluation reports, the one area of utilization where children in Medicaid have historically exceeded that of children in CHIP is in PMP utilization. This trend continued throughout 2002. However, it was interesting to note that CHIP Phase II showed a utilization trend more similar to Medicaid than CHIP Phase I. Also, the disparity in utilization between CHIP and Medicaid appears to be closing in 2002. All of these findings support the hypothesis that PMP utilization tends to be related to the age of the population. Since both children in Medicaid and CHIP Phase II cover ages 0 through 18, it would be expected that their utilization patterns would be similar. But up until 2002, the population in CHIP Phase I was mostly comprised of teenagers who are historically least likely to see a PMP. Now that this group is leaving CHIP Phase I because they are greater than 19 years of age, the data suggests that the utilization patterns in CHIP Phase I are more closely mirroring the other programs as the age distribution also becomes more similar (see Exhibit III.22).

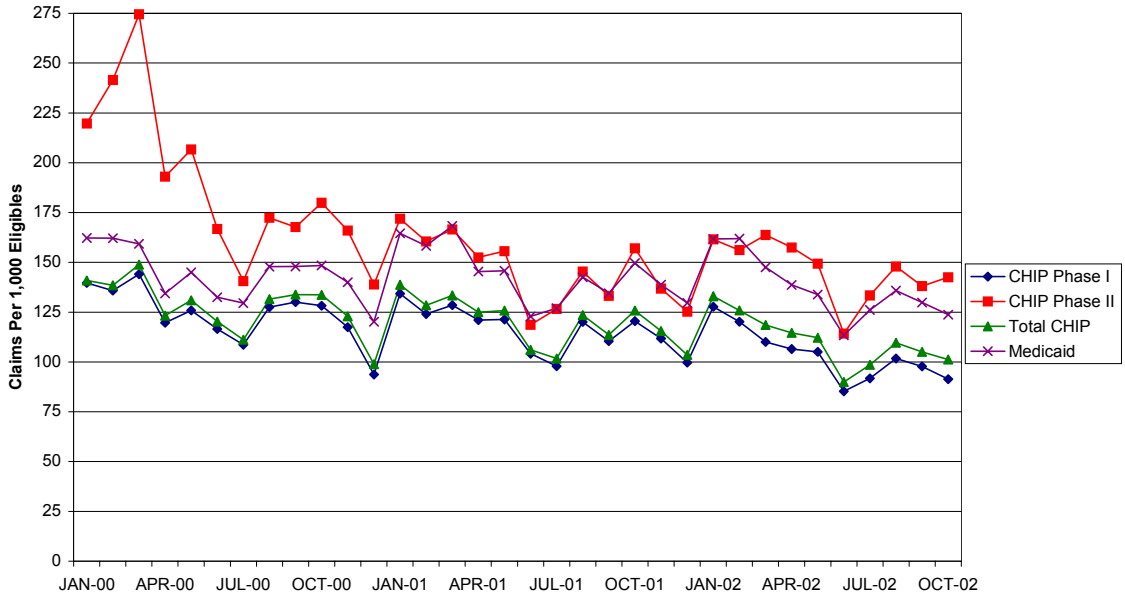
Utilization of non-PMP physicians follows trends similar to PMP utilization. Both Medicaid and CHIP Phase II utilize non-PMPs at about the same rate and slightly higher than CHIP Phase I (see Exhibit III.23). Utilization of non-PMPs is only slightly lower than that of PMPs for both CHIP and Medicaid.

Exhibit III.22
PMP Physician Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files through December 2002. Shadow claims (RBMC delivery system) included.

Exhibit III.23
Non-PMP Physician Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files through December 2002. Shadow claims (RBMC delivery system) included.

How does the utilization and payment of physician services for CHIP members compare across the three delivery systems?

Since members in the FFS delivery system do not select a PMP, utilization of PMP services was only compared between members in the PCCM and RBMC delivery systems. Overall the utilization rates between the two systems were similar. For non-PMP services, members in the FFS system have historically had utilization that was twice as high as that for members in PCCM or RBMC (mostly because they do not have to select a PMP). However, as the State has moved more members into managed care with the implementation of mandatory RBMC in five counties in 2002, the number of members in the FFS portion of the program has decreased significantly. The data from the latter portion of 2002 suggests that non-PMP utilization is now actually lower for FFS than for PCCM.

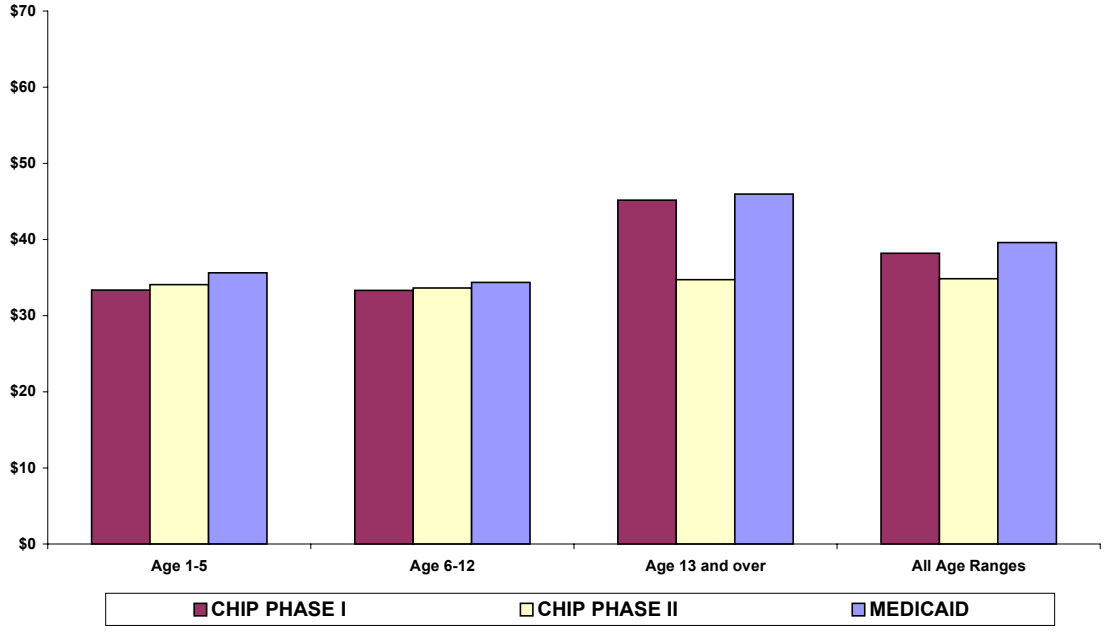
Similarly, when PMPMs were compared between FFS and PCCM for non-PMP services, the FFS PMPM ($10 to $12 per month) has historically been higher than PCCM ($8 per month). But these PMPMs have also come much closer in 2002 as the number of members in FFS has been sharply reduced.

Are there variations between the costs of physician services for CHIP and Medicaid members by age group?

There was little difference found in the average paid per claim for PMP services among younger children in 2002 between CHIP and Medicaid. For teenagers, both CHIP Phase I and Medicaid had higher average payments per claim than CHIP Phase II (see Exhibit III.24). There was also very little change in the average paid per claim (all ages) between 2001 and 2002 for CHIP or Medicaid.

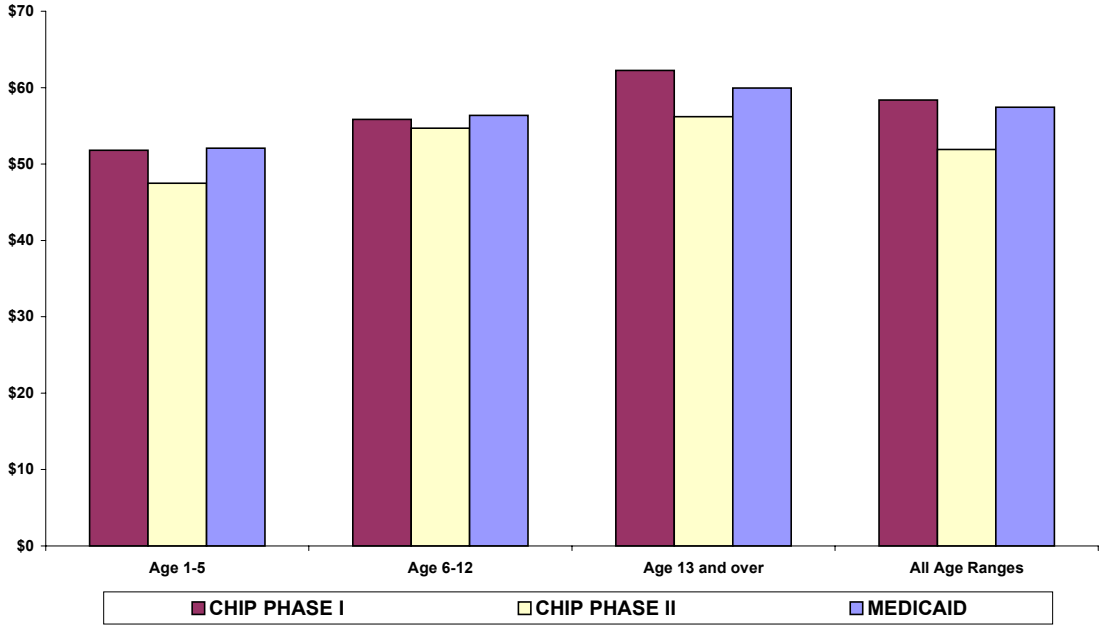
The average payment per claim for non-PMP physicians was almost 50% higher for all programs than the average payment per claim for PMP physicians. This is most likely due to the fact that the non-PMP physician group includes both general practitioners as well as all of the specialist physicians which usually have higher per visit charges. However, there was little variation between age groups across the programs. CHIP Phase I and Medicaid average payments per claim were slightly higher in 2002 ($58) than CHIP Phase II ($52) for non-PMP physician services (see Exhibit III.25).

Exhibit III.24
PMP Physician Average Paid Per Claim
For Dates of Service in Calendar Year 2002



Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

Exhibit III.25
Non-PMP Physician Average Paid Per Claim
For Dates of Service in Calendar Year 2002



Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

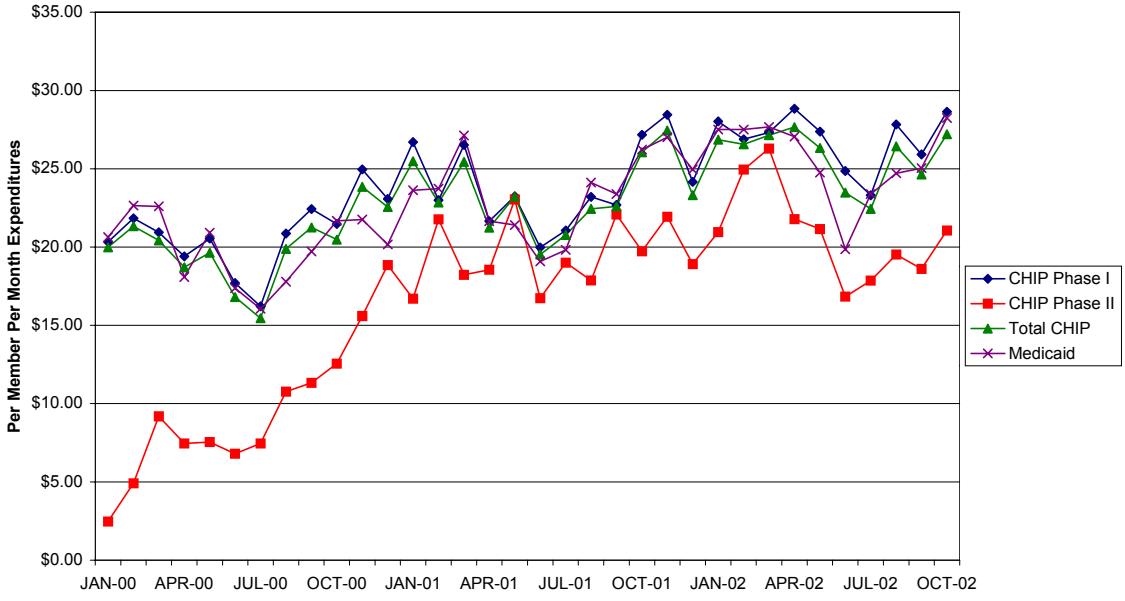
PHARMACY SERVICES

Although pharmacy expenditures have been growing for children in the CHIP and Medicaid programs, expenditures were relatively stable between 2001 and 2002.

How do PMPM expenditures compare between CHIP Phase I, Phase II and Medicaid for PMP and non-PMP physicians?

Over the last three years, pharmacy expenditure PMPMs for CHIP and Medicaid have grown from $20 per month to close to $30. However, it appears that most of this increase was in 2000 and 2001 for children. For the last two years, the PMPMs for CHIP Phase I and Medicaid have been the same and followed similar patterns. The pharmacy PMPM for CHIP Phase II children, on the other hand, continues to be less than the PMPM for the other two programs at approximately $20 per month (see Exhibit III.26).

Exhibit III.26
Pharmacy Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



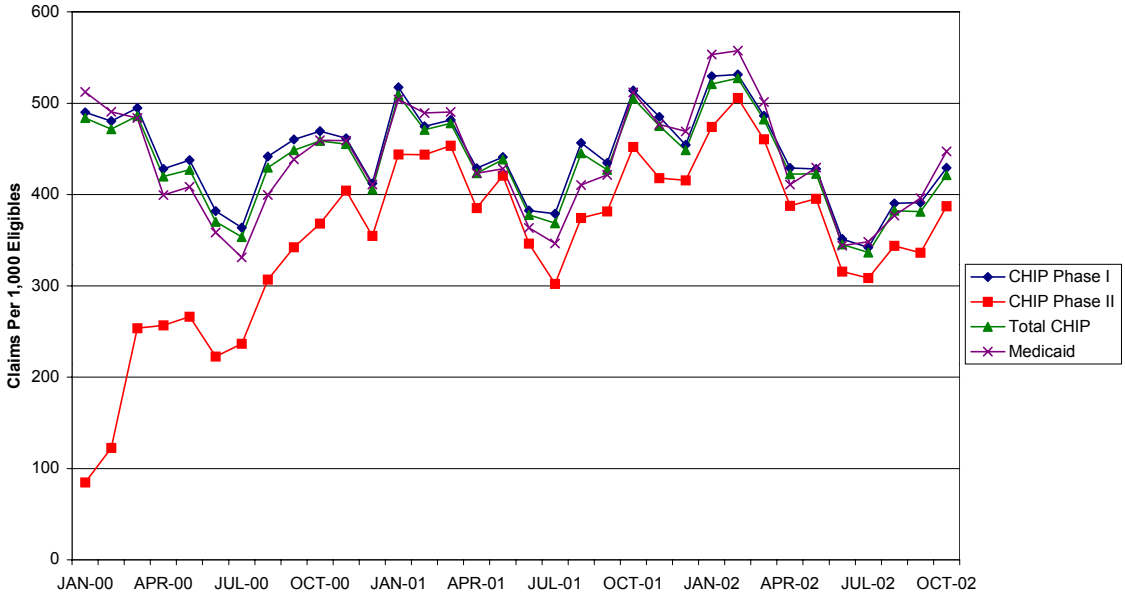
Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

How does utilization of pharmacy services differ for children in CHIP and Medicaid?

In general, it was found that children in all three programs are utilizing pharmacy services at the same rate (see Exhibit III.27). As shown in Exhibit III.26 where CHIP Phase II members had a

lower PMPM than CHIP Phase I or Medicaid, the similarity in utilization between the programs implies that CHIP Phase II members utilize less expensive scripts than CHIP Phase I or Medicaid members.

Exhibit III.27
Pharmacy Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files through December 2002. Shadow claims (RBMC delivery system) included.

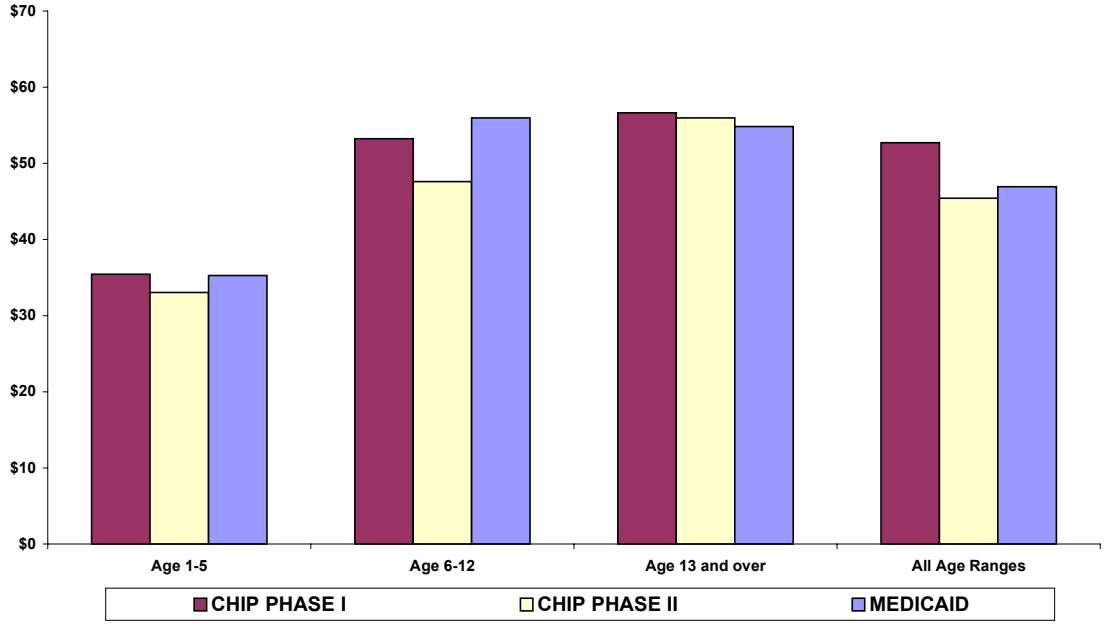
How does the utilization and payment of pharmacy services for CHIP members compare across the three delivery systems?

The majority of pharmacy claims across all three programs are incurred within the PCCM delivery system. Utilization in the PCCM system has been 50% to 100% higher than both the RBMC and FFS systems on a month-to-month basis. (The low utilization in the RBMC delivery system, however, may be due to an under-reporting of shadow claims in this delivery system.) When comparing PMPMs between PCCM and FFS, pharmacy expenditures are one of the few areas where the PMPM for FFS members is lower than PCCM members. One reason why this may be true is that children who have chronic health conditions and need regular scripts are more likely to be affiliated with a PMP (and therefore in the PCCM delivery system).

Are there variations between the costs of pharmacy scripts for CHIP and Medicaid members by age group?

As reported in the 2002 annual report, there are differences in the average paid per claim across age groups and these differences hold true in both CHIP and Medicaid. For example, children in the group under age five years have the least expensive claims while teenagers have the most expensive claims (see Exhibit III.28). Prior years found that the utilization of antidepressants and tranquilizers among teenage males accounted for much of the difference in the average payment per claim among age groups. In 2002, however, the difference between the average payments for children age 6-12 is similar to teenagers, especially in CHIP Phase I and Medicaid. Further research will be needed to determine if the children in the age 6-12 group are using the higher cost scripts used by teenagers (antidepressants and tranquilizers) more prevalently now or if the reason for the increase in the average payment per claim in this age group is due to other types of scripts. The average payment per claim for children in CHIP Phase II and Medicaid remained the same from 2001 to 2002 while the average for children in CHIP Phase I average went up 9%. Further research may be required to determine the reason for this difference.

Exhibit III.28
Pharmacy Average Paid Per Claim
For Dates of Service in Calendar Year 2002



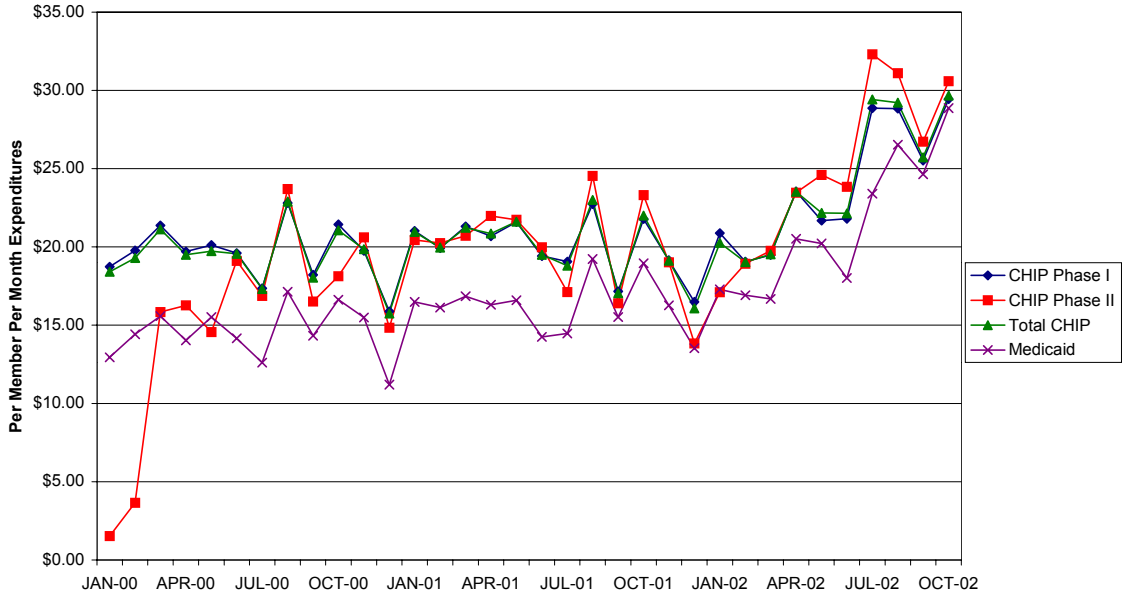
Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

DENTAL SERVICES

How do PMPM expenditures compare between CHIP Phase I, CHIP Phase II and Medicaid for dental services?

The PMPM for dental services for all children has grown close to 50% in the last three years from $20 per month to $30 per month. This appears to be a reflection of both higher utilization levels as well as higher payments per claim (including higher reimbursement to dentists for basic services). Historically, children in CHIP have had higher dental expenditure PMPMs than children in Medicaid. This is mostly attributable to higher utilization of services (see Exhibit III.29)

Exhibit III.29
Dental Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002

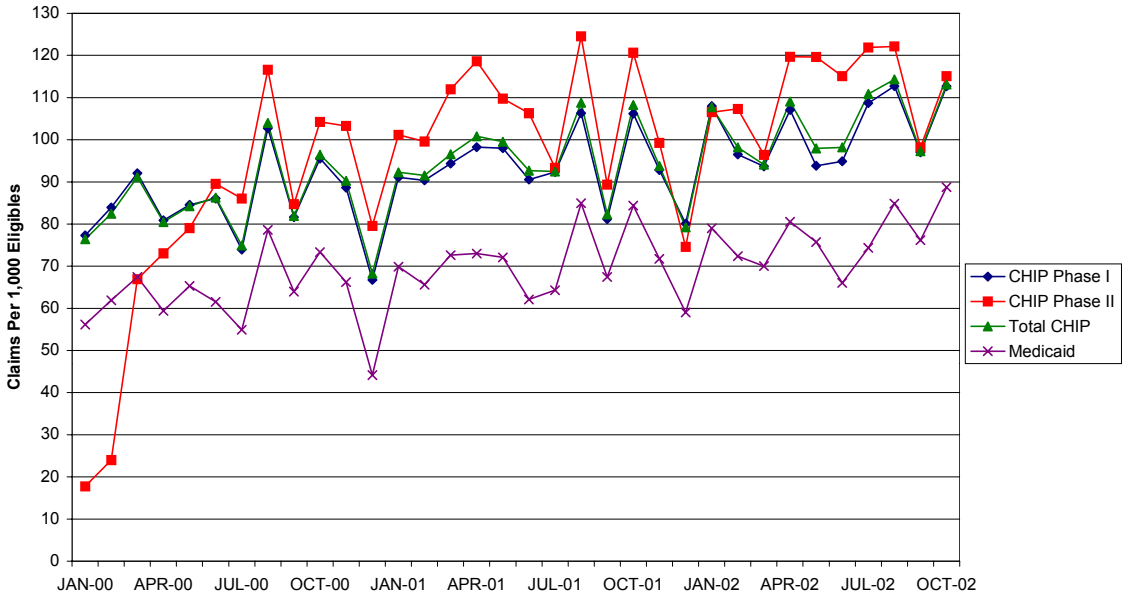


Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

How does utilization of dental services differ for children in CHIP and Medicaid?

Within Hoosier Healthwise, dental utilization for CHIP members has always been much higher than that for Medicaid members. Further, utilization of CHIP Phase II members is higher than CHIP Phase I members, but that gap has been closing in 2002 (see Exhibit III.30).

Exhibit III.30
Dental Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2000 - October 2002



Source: Dataprobe files through December 2002. Shadow claims (RBMC delivery system) included.

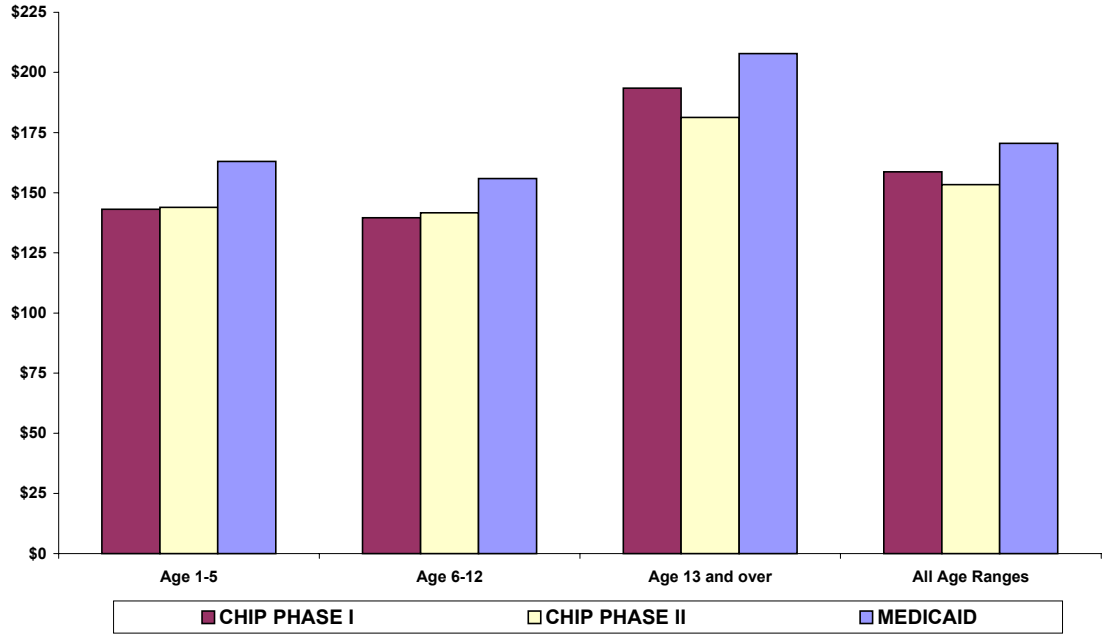
How does the utilization and payment of dental services for CHIP members compare across the three delivery systems?

CHIP members in the PCCM and RBMC delivery systems have shown very similar patterns in both dental utilization as well as PMPM expenditures. Utilization for these two delivery systems is twice that as seen in the FFS system. Likewise, the PMPM expenditures for PCCM and RBMC have been between $16 and $20 per month whereas they have been $8 to $10 per month for members in the FFS system. It should be noted that dental services are not covered by the managed care organizations in the RBMC delivery system. Therefore, unlike other categories of service, dental service PMPM expenditures can be analyzed for members in the RBMC system. For purposes of analyzing utilization and PMPM here, the members labeled RBMC are those members usually categorized in the RBMC system for their other services.

Are there variations between the costs of dental services for CHIP and Medicaid members by age group?

Average payments per claim for dental services were highest among children ages 13-18 for all programs, a finding consistent with trends found in the last three years. For the younger age groups, average payments are the same for both CHIP Phase I and Phase II and slightly higher for the same age groups in Medicaid (see Exhibit III.31).

Exhibit III.31
Dental Average Paid Per Claim
For Dates of Service in Calendar Year 2002



Source: Dataprobe files with payments made through December 2002. Shadow claims (RBMC delivery system) excluded.

SECTION IV
EVALUATION OF ACCESS AND QUALITY DATA FROM HOOSIER HEALTHWISE MONITORING ACTIVITIES

OVERVIEW

Section IV presents an overview of the ongoing monitoring activities as they relate to CHIP. There are a variety of monitoring efforts used to track the operation and performance of Hoosier Healthwise. As part of this annual evaluation report, the breadth and depth of these monitoring efforts were examined as well as the reported findings from monitoring activities. It should be noted that Hoosier Healthwise monitoring efforts focus on the program overall, although some CHIP specific information is available. Therefore, the CHIP Office has also conducted additional CHIP specific monitoring efforts to supplement overall Hoosier Healthwise monitoring.

The review of quality monitoring activities has been divided into two areas of review. The first area of focus includes what may be called "formal" quality monitoring activities where the focus is solely to monitor quality-related issues. The second grouping includes what may be called "indirect" quality monitoring activities and sources of information. This second group includes those activities and information that provide insight into quality issues but whose purpose is broader than quality monitoring and/or is used on an ad hoc basis to monitor quality.

The review of available monitoring information from both direct Hoosier Healthwise monitoring activities and non-quality specific data sources indicates that:

- There is a multifaceted monitoring approach taken to monitor the Hoosier Healthwise program that incorporates input from a variety of stakeholders and focuses on both qualitative and quantitative information.

- Processes exist to link issues with corrective action plans.

Overall, the evaluation of existing monitoring data support trends and findings from the data analyses presented in Section III. The three largest issues facing both Hoosier Healthwise and CHIP include:

- The completeness of the shadow claims data from the Risk-Based Managed Care (RBMC) portion of the program. This issue is being actively addressed by joint work between the State and the managed care entities.

- The ability to identify and track when children have received immunization services. This issue is also in the process of being addressed through the creation of an immunization registry.

- The availability of physicians services in some areas of the State. The availability of physicians and limiting the number of counties with full physician panels has been a goal that Hoosier Healthwise has been actively pursuing and continues to pursue. Changes to the auto-assignment process and the evaluation of the effect of this on physician satisfaction and supply is ongoing. At this time it is unclear if the physician supply issue is specific to Hoosier Healthwise or is common across both public and commercial insurers. If shortages in physician supply were found to affect both commercial plans as well as Hoosier Healthwise, than efforts to increase physician supply would need to include additional stakeholders beyond Medicaid.

FORMAL QUALITY MONITORING ACTIVITIES

Hoosier Healthwise has regular periodic formal mechanisms for monitoring quality and access issues. These include:

- Monthly Quality Improvement Committee (QIC) meetings
- Annual Member Survey
- Annual Provider Survey
- Evaluation of HEDIS Benchmarks

The results of these monitoring activities for 2002 are summarized below. These formal monitoring mechanisms and forums provide vehicles for program quality issues to be proactively addressed, to be monitored over time, and to be identified from a variety of input sources (members, providers, managed care entities (MCEs) and State staff).

Quality Improvement Committee Monthly Meeting Minutes for 2002

Monthly Quality Improvement Committee (QIC) meetings had at least one, usually more, representatives from each of the following parties in attendance:

- Each of the managed care entities (MCEs)
- AmeriChoice/Lifemark, who administers Prime*Step*
- Tucker Alan (the federally-required external quality review organization, or EQRO, for Hoosier Healthwise)
- Office of Medicaid Policy and Planning (OMPP)

Depending on the agenda topics, additional attendees included representatives from the CHIP program, various Hoosier Healthwise contractors and various guest speakers. A review of the issues addressed during 2002 highlights the role that the QIC meetings play in providing a forum for discussion of both short-term and long-term Hoosier Healthwise operational issues.

- *Mandatory RBMC Transition.* In 2002, mandatory managed care was implemented in five counties in the State. In order to track the transition of members into the RBMC network, a mandatory reporting process was established for RBMC enrollment. Each MCE was required to report enrollment data on a twice-monthly basis. Additional reporting requirements included the estimate of PMP contracts pending in order to respond to the Centers for Medicare and Medicaid Studies' (CMS') concerns about counties without RBMC networks. During QIC meetings, discussions focused on both the status of the member transition into MCEs as well as provider supply. Concrete solutions to potential problems were presented and discussed. For example, as a result of access concerns related to recruiting OB/GYN providers, particularly in Elkhart County, provisions were made to:

  - Include MCEs reimbursing providers on an out-of-network, fee-for-service basis
  - Allow Hoosier Healthwise members to receive services from providers in neighboring counties
  - Increase use of public health clinics

  Another discussion focused on identifying Illinois providers who should be recruited for participation in the upcoming mandatory RBMC program in Lake County. An OMPP survey was conducted to identify PMPs treating RBMC members but located in contiguous counties to the mandatory RBMC counties. OMPP encouraged the MCEs to recruit these PMPs in an effort to maintain access and continuity of care.

- *Member Grievance Process.* Indiana statute mandates the Department of Insurance (DOI) to collect and make available to the public data regarding grievances as well as HEDIS data. The QIC discussed the difficult issue of how to define a "grievance" versus a "complaint". Without a consistent definition of what should be reported, many states have found that grievance rates cannot be compared across MCEs. To meet this statutory mandate, OMPP added the term "inquiries" for reporting purposes and made a change in policy to substitute the term "complaint" with "grievance." This was significant because the new reporting policy requires issues formally treated as "complaints" now be termed "grievances", which requires MCEs to respond in writing to members (and providers). Previously, the policy required the MCEs only to respond to the more serious grievances. In addition, the need to use *reason codes* to allow grievances to be organized into quality-related and access-related issue categories for monitoring purposes was discussed.

- *Provider Grievance Process.* The provider grievance process was revised to include the addition of a grievance category for administrative-related issues. In addition, the appeals process was finalized and MCE requirements regarding provider disputes were also clarified.

- *Shadow Claims Validation Project.* The feedback from MCEs from the Shadow Claims Validation Pilot addressed many problems, including a low response rate. Based on the results of the pilot study, there was concern with the level of accuracy and completeness of the shadow claims data because less than half of the claims sample was determined to be accurate and complete. The committee noted that HEDIS rates would also be underreported using the current claims data and discussed whether it would be useful to apply resources toward improving the quality of data. The committee and OMPP decided on the following future steps:

  - Present the results to health plan CEOs in January 2003 and follow-up on shadow claims issues throughout 2003.
  - Have MCEs submit shadow claims action plans in 2003.
  - Evaluate the process between EDS (the fiscal agent) and MCEs to identify ways to improve data exchange.
  - Review denied claims to identify differences that may exist between denied claims and paid claims. (The pilot study excluded denied claims because denied claims are not reported to EDS.)
  - Consider evaluating panel size of providers that submitted claims for services that are not noted in the medical record.
  - Consider reducing the amount of time allowed for providers to submit claims from twelve months to six months. This would require a legislative change.

- *Immunization Registry (CHIRP).* The Indiana State Department of Health (ISDH) began a new web-based immunization data repository in January 2002. The new immunization registry program, called the Children and Hoosiers Immunization Registry Program (CHIRP), is HIPAA compliant. ISDH provider surveys indicated that over 80% of providers have the technical resources to actively participate in CHIRP. The goal of the program is to enroll all of the State's public providers in CHIRP by the end of 2002 and to begin private provider enrollment in 2003. MCEs are trying to improve reporting of immunization data by including language in provider contracts that requires providers to report immunization data to the MCEs. Another goal is to use CHIRP immunization data, in addition to claims data, to assess MCE HEDIS immunization coverage levels. QIC plans to look into the five-step process, first implemented by Arizona, for using registry data to assess HEDIS coverage levels.

- *Lead Screening.* The committee had a guest speaker to discuss legislation that addresses reporting of all blood lead levels for children, not just children with high levels. The purpose of the blood lead legislation is to bring the State into compliance with the Federal Children's Health Act of 2000. OMPP discussed at the September QIC meeting finding out from ISDH when they would be receiving data on lead screening.

In addition, both provider and member survey findings, as well as the collection and analysis of HEDIS quality measures, were discussed during QIC meetings. These monitoring activities and findings are individually discussed in greater detail below.

Member Satisfaction Survey

The State of Indiana's OMPP conducted a member satisfaction survey of Hoosier Healthwise members in all counties with current enrollment in September 2001 and who were enrolled in the program greater than six months, regardless if medical services were obtained. Surveys are based on one-to-one, telephone, and in-person interviews administrated by Hoosier Healthwise Benefit Advocates. Data was tracked by all Hoosier Healthwise members, CHIP Phase I and CHIP Phase II members.

Member satisfaction survey findings specific to CHIP Phase I and CHIP Phase II children are shown below and are compared to the findings of the total Hoosier Healthwise membership and to national averages based on the CAHPS - Medicaid Child survey tool. (Reference to "CHIP members" implies the parents/guardians of the children in CHIP). Overall, CHIP member satisfaction findings were very positive.

- Between 89% and 97% of all CHIP members rated physician courtesy, quality of care, staff courtesy, and time spent with their doctor "good" or "very good".

- Seventy-eight percent of all CHIP members (81% Phase I, 70% Phase II) were aware of the annual renewal requirement as compared to only 63% in the Hoosier Healthwise program.

- Three-quarters of all CHIP members described their current health status as "very good" (76%) (i.e. the top category) compared to less than two-thirds (61%) of the total Hoosier Healthwise program. (See Exhibit IV.1)

Satisfaction among members of Indiana's CHIP program also exceeded national averages of comparable surveys of children in Medicaid programs in all categories. The following criteria were analyzed to compare the satisfaction level of Hoosier Healthwise CHIP members to national averages.

- *Rating of Hoosier Healthwise Program.* The Hoosier Healthwise CHIP program exceeded the national average for overall rating of a health insurance plan (specific to Medicaid children). Sixty-one percent of all CHIP members (59% Phase I, 65% Phase II) gave Hoosier Healthwise the most favorable rating (i.e. "very good") versus 56% of health plan members nationally. Further, 88% of all CHIP members (90% of Phase I, 84% of Phase II) rated Hoosier Healthwise as either "very good" or "good" compared to 83% of Medicaid health plan members nationally. (See Exhibit IV.1)

- *Rating of Member's Overall Health.* The Hoosier Healthwise program average for all CHIP members reflects that they are more likely to rate their current health status as "very good" or "good" than members of other managed care organizations nationally. Ninety-five percent of all CHIP members rated themselves as having a high level of health versus 88% nationally. (See Exhibit IV.1)

Exhibit IV.1
Members' Ratings of Their Overall Health Status and Health Plan
Percentage of Members Giving the Specified Responses

Rating Question	NCBD Scale	NCBD Average	Hoosier Healthwise Program Average			
			Total	CHIP Total	CHIP Phase I Children	CHIP Phase II Children
Q34 Rating of All Health Care	9 to 10 ('Very Good')	63%	61%	76%	76%	75%
	7 to 8 ('Good')	25%	26%	19%	20%	19%
	Combined	88%	87%	95%	96%	94%
Q55 Rating of Health Insurance Plan	9 to 10 ('Very Good')	56%	59%	61%	59%	65%
	7 to 8 ('Good')	27%	30%	27%	31%	19%
	Combined	83%	89%	88%	90%	84%

Source: National CAHPS Benchmarking Database (NCBD), Medicaid - Child Survey 2000
and 2002 Hoosier Healthwise Member Survey Results and Analysis Final Report, March 2002

- *Rating of Hoosier Healthwise Doctor.* CHIP exceeded the national benchmark for member ratings of their personal doctor. Ninety-three percent of all CHIP members rated their doctor 'very good' or good' (i.e. top two ratings) compared to 81% nationwide rating their doctor in similar categories. (See Exhibit IV.2)

- *Rating of Hoosier Healthwise Specialist.* CHIP exceeded the national benchmark for member ratings of specialists they have seen. Ninety-four percent of all CHIP members (98% of Phase I, 87% of Phase II) rated their specialist 'very good' or 'good' (i.e. top two ratings) compared to 84% nationwide. (See Exhibit IV.2)

Exhibit IV.2
Members' Ratings of Their Personal Doctor and Specialist
Percentage of Members Giving One of the Top Two Most Positive Responses

Rating Question	NCBD Scale	NCBD Average	Hoosier Healthwise Program Average			
			Total	CHIP Total	CHIP Phase I Children	CHIP Phase II Children
Q7 Rating of Personal Doctor	9 to 10 or 7 to 8 ('Very Good' or 'Good')	81%	92%	93%	92%	93%
Q11 Rating of Specialist	9 to 10 or 7 to 8 ('Very Good' or 'Good')	84%	93%	94%	98%	87%

Source: National CAHPS Benchmarking Database (NCBD), Medicaid - Child Survey 2000
and 2002 Hoosier Healthwise Member Survey Results and Analysis Final Report, March 2002

The member survey was used to identify areas for improvement within Hoosier Healthwise member education. During QIC meetings, specific concerns identified through the overall survey of Hoosier Healthwise members included:

- Twenty-one percent of the members who responded stated that they hadn't received information on transportation services.

- Thirty-seven percent of members who responded stated that were not aware of the annual membership renewal process.

Provider Satisfaction Survey

The 2002 primary medical physician (PMP) survey conducted by OMPP was mailed to all PMPs who had participated in the Hoosier Healthwise program in 2001. The response rate for 2002 was lower than the past two years with 36% of PMPs (763) responding to the survey, which is slightly lower than 2001 (41% response rate) and 2000 (39% response rate).

Since the first PMP survey in 1995, the percentage of PMPs at least somewhat satisfied with the program has increased significantly from one-in-four (23%) to nearly three-quarters (71%) in 2001. Of those who responded to the 2002 survey,

- 14% were very satisfied and 57% were somewhat satisfied with Hoosier Healthwise
- 29% were at least somewhat dissatisfied (3% did not answer the question)

These satisfaction results are similar to last year's survey and are consistent across MCEs, practice types (e.g. Pediatrician, OB/GYN, etc.), practice profile (e.g., Independent practitioner, Primary Care Group Practices, etc.), and geographic location.

The areas with the lowest PMP satisfaction continue to include the auto-assignment process, patient compliance with physician's instructions, and patients keeping appointments. The

percent of providers dissatisfied with the auto-assignment process has decreased since 1999 (from 71% to 63%) but remained the same from last year at 63%.

In addition, provider satisfaction with their patient load was unclear. Unlike previous years' findings, "Losing patients previously served" is a much smaller problem. This statistic dropped from 39% of providers reporting it as a problem in 1997 to 15% in 2000 and again to 10% in 2001. On the other hand, the percent of PMPs suggesting they have "too many" Hoosier Healthwise patients steadily increased over the past four years from 18% in 1998 to 24% in 2001. This trend could translate into an access problem for members if PMPs resist increasing their panel capacity or decide to leave the program due to high patient loads.

In response to the findings of the provider survey, OMPP decided to consider making system changes to the auto-assignment algorithm to help address the panel size issue, to begin measuring panel size and auto-assignment on a monthly basis, and to make calls to 20 pediatricians to better understand their concerns.

HEDIS Measurements

The OMPP collected 2001 data for a subset of Health Plan Employer Data Information Set (HEDIS) measures in order to assess the performance of managed care entities (MCEs) in the Hoosier Healthwise program. A 2002 Hoosier Healthwise Briefing Paper was released on the results of this survey. Indiana-specific data for HEDIS measures was available only for the Medicaid population as a whole.

HEDIS is a set of standardized performance measures for the health care industry developed by the National Committee for Quality Assurance (NCQA) to assess the performance of managed care organizations. NCQA publishes annual HEDIS benchmarks separately for the Medicaid population with child-specific measures. For comparative purposes, national averages for the same HEDIS measures are presented along-side the Hoosier Healthwise averages in the exhibits that follow. NCQA data is given for both 2000 and 2001 to show how the national averages have changed over the past year.

Four Hoosier Healthwise managed care entities participated in the OMPP study:

- Harmony Health Plan of Indiana
- MDWise
- Managed Health Services
- Prime*Step* (the PCCM program)

Five HEDIS measures addressing key health care issues specific to children/adolescents and pregnant mothers were analyzed. Hoosier Healthwise data was compared to the NCQA median (50^{th} percentile) data for each measure in order to compare Indiana's performance to audited Medicaid plans nationwide. It should be noted that Hoosier Healthwise data is a weighted

average across the four managed care entities whereas NCQA median data is an unweighted rate across health plans, meaning health plans with large and small numbers of members count equally. This provides information on the "average" health plan as opposed to the "average" health plan member.

The key findings from NCQA 2000 and 2001 and Hoosier Healthwise 2001 data are discussed below:

- *Childhood and Adolescent Immunization Status.* Attainment of immunization goals continues to be difficult to measure. It has been a recognized issue for multiple years that immunization data is likely to be underreported for Hoosier Healthwise, in part due to claims that are not submitted for members who were immunized at local Health Department clinics. Analysis of available data found that the Hoosier Healthwise program immunization average was at least twenty percent below the benchmark median for all childhood and adolescent vaccines. Vaccinations measured included the MMR, Hepatitis B, and other common vaccinations recommended for young people. Currently, the ISDH is implementing a statewide immunization registry that will work to increase the amount of vaccination information shared among health care providers.

- *Access and Availability of Care.* The benchmark for children's access to primary care practitioners measures the percent of children by age category who visited with an MCO primary care practitioner at least once during the year. The Hoosier Healthwise program average was similar to the NCQA median for 2001 across all age groups. (See Exhibit IV.3)

Exhibit IV.3
Percentage of Children with a Visit to a Primary Care Practitioner

Children's Access to Primary Care Practitioners			
Age	NCQA Medicaid Median		Hoosier Healthwise Program Average 2001
	2001	2000	
12 Months - 24 Months	93%	90%	91%
25 Months - 6 Years	79%	78%	77%
7 Years - 11 Years	81%	80%	81%

Source: National Committee for Quality Assurance (NCQA) HEDIS Medicaid Means & Percentiles, 2000 and 2001 and Hoosier Healthwise Briefing Paper: 2002 HEDIS Data Collection and Reporting Results

- *Frequency of Care.* The benchmark for well-child or well-care visits for adolescents evaluates the percent of children visiting the doctor by the number of visits and by age. Younger children tended to utilize services more frequently than older children both nationally and in Indiana. Approximately 89% of children nationwide and 90%

of children in Hoosier Healthwise had one or more visits to a doctor within the first 15 months of life. Nationally, only 53% of children ages 3 through 6 and 28% of adolescents ages 12 to 21 had a visit to the doctor in 2001. (See Exhibit IV.4)

Exhibit IV.4
Percentage of Children Receiving Well-Child Visits

Number of Visits	NCQA Medicaid Median		Hoosier Healthwise Program Average 2001
	2001	2000	
Well-Child Visits in the First 15 Months of Life			
No Visits	5%	7%	10%
One Visit	5%	6%	8%
Two Visits	7%	8%	10%
Three Visits	10%	10%	13%
Four Visits	14%	14%	17%
Five Visits	18%	17%	22%
Six or More Visits	35%	27%	20%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
One or More Visits	53%	49%	46%
Percentage of Adolescents Ages 12 to 21 Receiving One or More Well-Care Visits			
One or More Visits	28%	26%	23%

Source: National Committee for Quality Assurance (NCQA) HEDIS Medicaid Means & Percentiles, 2000 and 2001 and Hoosier Healthwise Briefing Paper: 2002 HEDIS Data Collection and Reporting Results

INDIRECT QUALITY MONITORING ACTIVITIES AND INFORMATION SOURCES

In addition to operational activities that are directly designed to monitor quality, there are additional sources of Hoosier Healthwise information that also provide insight into quality-related issues. This portion of Section IV addresses four of these indirect informal measures of quality:

- Auto-assignment rates (the rate at which members do not select a PMP but are assigned one) may be used as an indicator of members' future access to services and satisfaction with the system.

- Disenrollment rates (the rate at which members leave Hoosier Healthwise), when linked with the reason for disenrollment, may be an indicator of program dissatisfaction.

- Physician panel capacity is an indicator of the ease with which members can access physician services once they are enrolled in the system.

- HelpLine statistics may be used to measure quality issues with Hoosier Healthwise or information on the program that may not be reaching members effectively.

Hoosier Healthwise findings related to each of these indirect measures of quality are discussed below.

Auto-Assignment

A study of auto-assignment findings was conducted by EP&P based on a review of data from Indiana's DataProbe system for the period January 2000 to December 2002. The auto-assignment process is used when a member fails to select a PMP within 30 days of being determined eligible for Hoosier Healthwise. In this case, the member will be assigned to a PMP through the auto-assignment process, a mandatory federal requirement for the Hoosier Healthwise managed care program. A low auto-assignment rate indicates members are taking the initiative to choose a PMP on their own.

Through various initiatives and by identifying ways to improve the enrollment and auto-assignment process, the Hoosier Healthwise program has been successful in reducing the default auto-assignment rate. These initiative include adding providers in hard to reach areas as well as implementing mandatory managed care in five counties in 2002. The auto-assignment rates reported in the previous annual evaluation report indicated a low overall rate for children in Hoosier Healthwise of 3.8%, with CHIP Phase II having the lowest rate of 3.0%. The overall auto-assignment rate for children in Hoosier Healthwise decreased again to 3.6% in 2002. This decrease represented an overall drop of 38% in the past two years (2000 - 2002). Other

significant findings indicate that in calendar year 2002, auto-assignment rates for each group studied were below 5%.

- Similar to last year, CHIP Phase II had the lowest auto-assignment rate and CHIP Phase I had the highest program average auto-assignment rate in 2002. Average CY 2002 program auto-assignment rates were 3.5% for Medicaid, 4.4% for CHIP Phase I, and 2.4% for CHIP Phase II.

- CHIP Phase I's auto-assignment rate has declined steadily each year. Between 2000 and 2002, CHIP Phase I had the greatest decrease in auto-assignment rate, dropping from 7.6% to 4.4%.

- After a significant drop last year, Medicaid's auto-assignment rate remained stable from 2001 to 2002.

The findings of this analysis were compared to findings from an OMPP January 2003 report (Hoosier Healthwise Briefing Paper) on the auto-assignment process and it was found that EP&P's analysis showed slightly lower rates. The difference can be attributed to the fact that EP&P's analysis focused solely on children in Hoosier Healthwise whereas the OMPP study also included adults. It may be inferred from the differences that parents are more likely to select a doctor for their children than for themselves.

Disenrollment

Analysis of monthly disenrollment data from 2002 is used to measure when and why members are switching primary medical providers (PMPs) within Hoosier Healthwise or disenrolling from the program altogether. As in past reports, the analyses included a focus on the most common access reasons for disenrollment from a PMP and compared them to the previous year's finding.

Within this evaluation, access is defined as both the ease with which CHIP-eligible children are able to enroll in the program as well as the access they have to services once they are enrolled. As found in previous years, access issues tend to remain a small portion of the reasons why members switch PMPs or disenroll from Hoosier Healthwise. Specifically, the access issues of "inconvenient location", "transportation problems", and "network limitations" were reviewed because they were found to be the most common access reasons for disenrolling from a PMP. Results from this year's data were found to be similar to last year for all reasons except "transportation problems." The following access issues are tracked:

- Inconvenient Location
- MCO Ancillary Service Access Issues
- Network Limitations
- PCCM Ancillary Service Access Issues
- PMP Panel Full

- Transportation Problems
- Unable to Obtain Referral

As seen in Exhibit IV.5, access issues make up a very small portion of reasons for disenrolling from a PMP. All access issues combined make up only 3% of all reasons for disenrollments. Panel capacity was the most frequent reason related to access for members to switch PMPs in 2002. More than 2% of all disenrollments were attributed to a PMP's panel being full.

Exhibit IV.5
Percent of Access-Related Reasons for Disenrollment from a PMP

Reason	Total	Percent of Total
PMP Panel Full	11,803	2.1%
Inconvenient Location	4,062	0.7%
Network Limitations	1,406	0.2%
Transportation Problems	424	0.1%
MCO Ancillary Service Access Issues	40	0.0%
Unable to Obtain Referral	34	0.0%
PCCM Ancillary Service Access Issues	22	0.0%
All Access Issues	**17,791**	**3.2%**
All Non-Access Issues	**546,501**	**96.8%**
Total	**564,292**	**100%**

Source: AmeriChoice Monthly Disenrollment Data, 2002

For calendar year 2001 to 2002, disenrollment for reasons of "Network Limitations" increased and for "Inconvenient Location" and "Transportation Problems" decreased. (See Exhibit IV.6 on the next page)

Exhibit IV.6
Percent Change in Disenrollment for Specified Reasons 2001 - 2002

	Number of Disenrollments 2002	Number of Disenrollments 2001	Percent Change 2001 to 2002
Inconvenient Location	4,062	4,503	-10%
Transportation Problems	424	1,140	-63%
Network Limitations	1,406	924	52%

Source: AmeriChoice Monthly Disenrollment Data, 2002

Panel capacity was also the most frequent access-related reason for disenrollment among all four MCE's. Harmony had the highest percent of disenrollments due to full panels (2.7%) compared to the other MCEs.

Access issues across MCEs made up a small percent of reasons for disenrollment from Hoosier Healthwise. Compared to the other MCEs, Prime*Step* had the largest number of disenrollments in 2002 (347,849) and made up the largest percent of Hoosier Healthwise disenrollments related to access (2%). However, Harmony had the highest percent of access-related disenrollments (4.2%) out of all the health plans. (See Exhibit IV.7)

Exhibit IV.7
Access-Related Disenrollment Across Indiana's Managed Care Entities

Reason	Harmony	Percent of Total	MDWise	Percent of Total	MHS	Percent of Total	PrimeStep	Percent of Total
All Access Issues	1,332	4.2%	1,970	2.5%	3,371	3.2%	11,118	3.2%
All Non-Access Issues	30,215	95.8%	78,096	97.5%	101,459	96.8%	336,731	96.8%
Total	31,547		80,066		104,830		347,849	
Access Issues as Percent of Hoosier Healthwise Total	0.2%		0.3%		0.6%		2.0%	
Non-Access Issues as Percent of Hoosier Healthwise Total	5.4%		13.8%		18.0%		59.7%	

Source: AmeriChoice Monthly Disenrollment Data, 2002

Pediatric PMP Panel Capacity

This evaluation examined the number of pediatric physicians enrolled in Hoosier Healthwise over calendar year 2002 in order to measure member's access to care. Pediatric providers include General Practice, Family Practice, and Pediatrician PMPs but do not include Internal Medicine, OB/GYNs or PMPs who only treat patients older than 17. While the number of pediatric providers has increased, it appears that this increase is not keeping up with member growth. The following are key findings:

- The number of pediatric providers has increased slightly from 1,500 in September 1999 to 1,700 in December 2002.

- The average number of Hoosier Healthwise enrollees per pediatric PMP has increased slightly from 212 in September 1999 to 234 in December 2002.

- Over half of the pediatric PMP panels are full. This has increased from 37% in September 1999 to 52% in December 2002 causing concern for members' access to care through a pediatric physician.

In addition to studying the number of physicians available to children and adolescents, this evaluation also examined the supply of pediatric physicians within counties. Primary Medical Providers (PMP) negotiate with the State to determine their "panel size", i.e. the maximum number of members they will accept. In addition to understanding the actual number of pediatric physicians in a county, one must also assess whether or not the panels for these PMPs are full or are accepting new members in order to get a true understanding of members' access to care.

This evaluation examined panel size on a statewide and county-by-county basis (See Exhibit IV.8 on the next page). The analysis of panel size for Hoosier Healthwise as of January 2003 showed that:

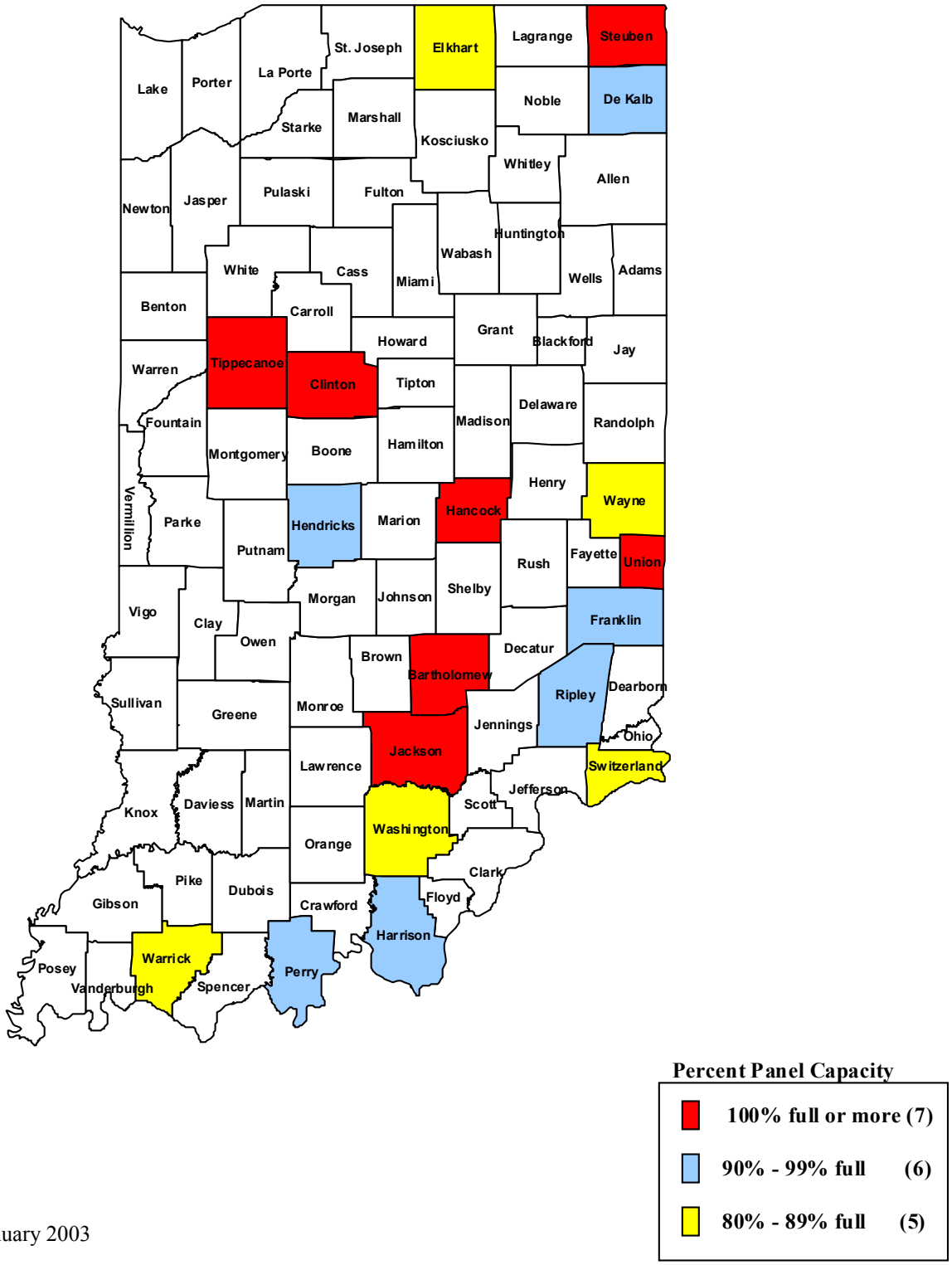
- Seven counties had full provider panels as of January 2003. Specifically, Bartholomew, Clinton, Hancock, Jackson, Tippecanoe (urban counties) and Steuben and Union (rural counties) counties have full pediatric provider panels.

- Only six counties reported full panels last year, with Clinton, Bartholomew, Jackson, and Union being four among the six. Notably, Elkhart (urban county) and Benton (rural county) are no longer at full capacity, with Elkhart dropping to 85% of full capacity in 2002 and Benton to only 28%. Steuben and Tippecanoe counties increased from below full capacity to 102% and 115% full capacity, respectively.

- A total of 18 counties had panels above 80% full as of January 2003. Three were in the North region, six in the Central region, and nine in the South region.

- Of all counties above 80% capacity, Elkhart County is the only mandatory MCO county. Three counties are adjacent to mandatory MCO counties: Dekalb (next to Allen county), Hendricks (next to Marion county), and Hancock (next to Marion county).

Exhibit IV.8
Measure of Pediatric PMP Panel Capacity By County



Percent Panel Capacity

100% full or more	(7)
90% - 99% full	(6)
80% - 89% full	(5)

Source: OMPP, January 2003

HelpLine Statistics

This section analyzes the nature of the issues received through the Hoosier Healthwise HelpLine offered to members. Calls were tracked by issue codes on a month by month basis for 2002. Although the predominant reason that members called the HelpLine in 2002 was for inquiries on recipient or PMP eligibility status, members also had the opportunity to report issues surrounding the quality of services provided. Therefore, issues pertaining to quality were pulled out and analyzed in terms of frequency as a percent of total calls received.

Overall, the volume of calls received through HelpLine varied over the year by nearly 100% with sharp increases and decreases in the latter part of the year (July through December). The number of calls was at a low of 6,500 in June and reached a peak of 12,700 in October.

In general, calls relating to quality issues represented a small percent of overall calls and remained below 5% of total call volume throughout the year. On average, quality-related calls made up 3% of monthly calls in 2002. Also, as total call volume increased or decreased over the year, the percent of quality-related calls remained relatively constant.

The following is a list of all issues related to quality that members reported in 2002.

- Appointment Delays
- Inconvenient Location
- Insufficient After-Hours Coverage
- MCO Ancillary Service Access Issue
- PCCM Ancillary Service Access Issues
- Physician/Patient Relationship Unacceptable
- Quality of Service Issues
- Transportation Problems
- Treatment by Staff
- Unable to Obtain a Referral
- Unsatisfactory Communication
- Unsatisfactory Quality of Care
- Untimely Communication
- Waiting time

"Inconvenient Location" was the most frequent reason members called with complaints related to quality, as they accounted for nearly half of all quality-related calls in 2002. (See Exhibit IV.9 on the next page)

Exhibit IV.9
Total Volume and Percent of Quality-Related Calls for 2002

	Total Calls	Total Quality-Related Calls	Inconvenient Location
Total Number of Calls	115,181	3,524	1,731
Percent of Total Calls	100.0%	3.1%	1.5%
Percent of Total Quality Calls	N/A	100.0%	49.1%

Source: AmeriChoice Monthly Disenrollment Data, 2002

CONCLUSION

The formal monitoring of Hoosier Healthwise includes input from State staff, providers and members and focuses on both process issues and quality issues. The monthly QIC meetings are a cornerstone of the formal monitoring process because they allow issues to be proactively identified and action plans developed in a setting that involves multiple stakeholders. The use of the QIC meetings to address the five-county transitions of members to mandatory managed care during 2002 is an example of how the QIC meetings can be used to develop monitoring guidelines and processes in anticipation of a potential issue. In addition, the QIC meetings were used to address issues identified from the member and provider survey results, such as provider concern with the auto-assignment process. The linking of issues across monitoring activities is another strength of the QIC meetings.

Informal monitoring activities, such as HelpLine statistics and the low rate of auto-assignments, support member satisfaction with the program. Disenrollment rates and physician panel capacity are two areas that continue to be evaluated through monitoring efforts.